Minutes of the meeting of the Finance Committee of the Board of Directors of the Cook County Health and Hospitals System held Friday, April 20, 2012 at the hour of 8:00 A.M., at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Carvalho called the meeting to order. A quorum was not present; as a result, the Committee received information but did not take action on any items. It was noted that any action items on the agenda would be presented directly to the Board for consideration on April 27, 2012.

Present: Chairman David Carvalho and Directors Luis Muñoz, MD, MPH (2)

Board Chairman Warren L. Batts (ex-officio) and Directors Hon. Jerry Butler and Ruth M. Rothstein

Note: Director Heather O'Donnell, JD, LLM, was present telephonically; however, due to the lack of a quorum, she was unable to participate in the meeting as a voting member.

Absent: Directors Quin R. Golden and Jorge Ramirez (2)

During the meeting, Chairman Carvalho noted that, due to the lack of a quorum, the Committee will review and discuss the items on the agenda, but will be unable to take action; any action items on the agenda will be presented directly to the Board for consideration at the meeting of April 27, 2012. Additionally, he noted that the Office of the General Counsel is currently working on an amendment to the Rules of the Board which will allow a Board Member who is not a member of a Committee to temporarily serve on a Committee, for quorum purposes.

Additional attendees and/or presenters were:

Anna Ashcraft - Cook County Real Estate Management Division
Gina Besenhofer – System Director of Supply Chain Management
John Cookinham – System Interim Chief Financial Officer
Helen Haynes – System Associate General Counsel
Dorothy Loving – Executive Director of Finance
Terry Mason, MD – System Chief Medical Officer
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer
Deborah Santana – Secretary to the Board

II. Public Speakers

Chairman Carvalho asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore Concerned Citizen

III. Action Items

A. Minutes of the Finance Committee Meeting, March 23, 2012

This item will be presented for consideration and acceptance at the May 24, 2012 Meeting of the Finance Committee.

III. Action Items (continued)

B. Contracts and Procurement Items (Attachment #1)

This item will be presented for consideration and approval at the April 27, 2012 Meeting of the Board of Directors.

Gina Besenhofer, System Director of Supply Chain Management, presented the requests for the Committee's review and discussion.

Anna Ashcraft, Director of the Cook County Real Estate Management Division, provided additional information regarding request number 1. Chairman Carvalho inquired regarding whether some projects will be placed on hold while this plan is being developed and completed. Ms. Ashcraft responded in the negative; she added that projects that appear to be non-essential will be slowed down while the plan is developed. With regard to the question of re-use of the old Cook County Hospital Building, Ms. Ashcraft stated that the plan will be to look at the ability to re-use that building, as had been previously recommended, and still have adequate property on the campus to accommodate the needs for Fantus Clinic and parking.

Dr. Terry Mason, System Chief Medical Officer, inquired regarding the entities that will be working on this project with U.S. Equities. Ms. Ashcraft responded that the team is comprised of approximately seventy-five to one hundred individuals; she added that there are numerous companies that are involved in the project.

Board Chairman Batts requested additional information regarding request number 4; this is a request to extend, amend and increase the contract with Health Management Associates (HMA). Dr. Ram Raju, Chief Executive Officer, responded that HMA has been working with the System for many years; Matt Powers, of HMA, has been instrumental in assisting the System with the Section 1115 waiver application activities. Dr. Raju stated that HMA will be assisting the System to implement and operationalize the medical home structure.

The Committee received a brief update regarding the recruitment for the position for which services are being contractually provided under request number 3. John Cookinham, System Interim Chief Financial Officer, stated that the position has been posted and a list of candidates is forthcoming; once the list of candidates is received from Human Resources, the process of interviewing will begin.

C. Supplemental Contracts and Procurement Items (backup to follow)

There were no Supplemental Contracts and Procurement Items for the Committee to discuss.

D. Approval of Transfer of Funds requests

There were no Approval of Transfer of Funds requests for the Committee to discuss.

E. Any items listed under Sections III and IV

IV. Recommendations, Discussion/Information Items

A. Notification of Emergency Purchases

Ms. Besenhofer informed the Committee that an emergency purchase has been made for the purchase of two portable ultrasound units for the Emergency Department at Stroger Hospital. She stated that formal notification of this purchase will be sent out after this meeting.

B. Financial Reports through February 2012 (Attachment #2)

This item will be presented for consideration and acceptance at the May 24, 2012 Meeting of the Finance Committee.

Dorothy Loving, Executive Director of Finance, presented the Financial Reports through February 2012. The Committee reviewed and discussed the information.

During the Committee's discussion of the drop-off in revenues, Chairman Carvalho noted that, last year, when the System's revenues were lower than expected, the cause was partly attributed to the delayed budget process; under the FY2011 budget process, revenue and expense projections were made in July but the budget was not finalized and approved until February, which is three months into the fiscal year. For FY2012, Chairman Carvalho stated that the budget process was not delayed; it was considered and approved according to plan. As there was no delay in the budget process, he inquired as to any other factors that may be contributing to the System's revenue shortfalls for 2012. He noted that the budget was approved in November 2011, and the System's revenue projections were off-target by December 2011, which is the first month of the fiscal year; he asked how the actual revenues could deviate from the System's revenue projections within that short period of time.

Mr. Cookinham responded that management continues to try to accelerate the processing of applications payments to the System; he noted that there has been progress, but issues remain. Dr. Raju provided an example relating to delays in Medicaid claims processing. He stated that when the retroactive rate adjustment took place, claims that were being processed were rejected, because they were based on the old rate; he added that, while the higher rate will be beneficial to the System, the rejected claims will now have to be re-submitted, which will take additional time.

Dr. Raju also summarized the System's strategy for budgeting in the face of uncertainty regarding revenues. To budget based upon a very conservative, low-end forecast of revenues would require significant reductions in staff and services, doing irrevocable damage to the System and its clients. Instead, the System adopts a reasonable but aggressive target for revenues, and then works to achieve those revenues, or come as close as possible under the circumstances.

V. Report from Chief Financial Officer (Attachment #3)

A. Update on Revenue Cycle Initiatives
B. Financial Dashboard
C. CareLink Policy

Dr. Raju provided an update on Governor Quinn's plan to stabilize Illinois' Medicaid system. As part of his update, Dr. Raju distributed three documents that were released by the Governor's Office: a press release regarding the plan, a list of proposed spending reductions, and a fact sheet regarding the subject (Attachment #4).

V. Report from Chief Financial Officer (continued)

Mr. Cookinham provided an overview of the information included in his report. The Committee reviewed and discussed the information.

Dr. Raju provided an update on the subject of pending Medicaid applications for System patients that are awaiting processing at the State. He stated that there were 14,000 pending Medicaid applications at the State at the beginning of the year; currently, there are 7,000 pending Medicaid applications, out of which 4,000 are in the appeals process. Once those have cleared the appeal process, the System should be down to 3,000 pending applications; he added that the System is approaching the normal, steady level of pending applications, which is 2,000.

During the presentation of Mr. Cookinham's report, Dr. Raju provided information on the total amount of charity care provided annually by the System. He stated that approximately $300 million in charity care is provided each year, up-front; the additional amount for those services for which the System will not receive payment increases the total annual amount to $500 million dollars in charity care provided by this organization. Dr. Raju pointed out that this amounts to at least half of the System's annual budget.

VI. Adjourn

As the agenda was exhausted, Chairman Carvalho declared the meeting ADJOURNED.

Respectfully submitted,
Finance Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXX
David Carvalho, Chairman

Attest:

XXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

COOK COUNTY HEALTH AND HOSPITALS SYSTEM
ITEM III(B)
APRIL 20, 2012 FINANCE COMMITTEE MEETING
CONTRACTS AND PROCUREMENT ITEMS

Request #	Vendor	Service or Product	Fiscal Impact	Affiliate / System	Begins on Page #
Capital Program Item - Enter Into and Execute Contract					
1	U.S. Equities Realty	For the Real Estate Asset Strategic Realignment Plan Project		System	2
Amend Contracts					
2	AmeriSourceBergen Drug Corporation	Service - DSH/340B consulting	No fiscal impact	System	4
3	Kimberly Velasquez	Service - professional services	$150,000.00	System	6
Amend, Extend and Increase Contract					
4	Health Management Associates (HMA)	Service - professional services	$509,250.00	System	7
Execute Contracts					
5	Boston Scientific	Product - urological supplies	$797,366.00	SHCC	8
6	Medrad Inc.	Product - computed tomography (CT) syringes	$644,895.00	PHCC, SHCC, OFHC	9
7	CDW-G	Product - SAP licenses, wireless access points and UPS batteries	$566,698.19	System	10
8	W.L. Gore & Associates, Inc.	Product - vascular tissue	$400,000.00	SHCC	12
9	Translogic Corporation d/b/a Swisslog Healthcare	Product and Service - pneumatic tube system maintenance services, supplies and system upgrade	$352,000.00	SHCC	14
10	Olympus Anesthesia - Endoscope Division	Product - endoscopes, colonoscopes image management system	$258,414.77	PHCC	16
11	Rush Medical Laboratories	Service - renal biopsy consultations	$156,278.00	SHCC	18

BUREAU OF ECONOMIC DEVELOPMENT
OFFICE OF REAL ESTATE MANAGEMENT
OFFICE OF CAPITAL PLANNING AND POLICY

PROPOSED CONTRACT

Transmitting a Communication, dated April 10, 2012 from

ANNA ASHCRAFT, Director, Real Estate Management Division
JOHN COOKE, Director, Office of Capital Planning and Policy

Requesting authorization for the Chief Procurement Officer to enter into and execute a contract in the amount of $9,844,265 with U. S. Equities Realty, Chicago, Illinois, for the Real Estate Asset Strategic Realignment Plan Project. This contract provides for professional services for a comprehensive plan for efficient space use and long-range capital improvements for all property owned by Cook County. U. S. Equities Realty was selected through a Request for Proposals process. Cost savings for this procurement are estimated at $155,735.

Reason:

The purpose of this Contract is to provide the County with a Real Estate Asset Strategic Realignment Plan that will include a plan for efficient use of the County's real estate assets, and a long-range capital improvement plan. This project combines three assessment projects approved in the 2012 Capital Improvement Plan: 1. Corporate Space Utilization & Facility Condition Assessment ($3,000,000); 2. Court System and Corrections Space Utilization & Facility Condition Assessment ($3,000,000); and 3. Health & Hospitals System space Utilization & Facility Condition Assessment ($3,000,000). In addition, $1,000,000 will be transferred from the Cook County Hospital Campus Redevelopment Plan. The goals and objectives of the Plan include: strategic planning for the use of County real estate assets; developing strategies and procedures for the control, management and allocation of real estate assets; developing data to increase accountability for real estate uses and enable cost savings; prioritizing improvements identified as necessary for strategic assets by completing a complete facilities condition inventory and assessment; and developing a plan to reduce real estate portfolio and costs by disposing of excess real estate through sales, leases or other appropriate arrangements.

This is a joint project undertaken by the Real Estate Management Division and the Office of Capital Planning and Policy.

Estimated Fiscal Impact: $9,844,265.00

20000 County Physical Plant

Contract Term: Two years, commencing on the date of Board approval.

Approval of this item would commit Fiscal Years 2012 and 2013 funds.

Request #
1

FACT SHEET

Real Estate Asset Strategic Realignment Plan (REASRP)
Consultant: U. S. Equities Realty

PROJECT DESCRIPTION & INTENT OF SERVICES

This Project will result in a Real Estate Strategic Realignment Plan (REASRP) to be developed based on the outcome of a complete space utilization study and a facilities condition assessment of all County facilities. The goals of the Project include the following:

- Align Cook County real estate assets with the County's strategic objectives
- Improve efficiency in the use of real estate assets, as appropriate to enhance operational efficiency
- Develop standards, strategies and procedures for the control and allocation of real estate assets, together with a data base and supporting documentation to enable the County to manage its real estate assets on an on-going basis
- Reduce the cost of occupying real estate assets
- Perform a complete facilities condition inventory and assessment
- Develop a long-range capital plan for improvements identified as necessary for strategic assets
- Develop a plan to reduce real estate portfolio and costs by disposing of excess real estate through sales, leases or other appropriate arrangements in a market-sensitive time frame and in a manner that appropriately protects the public interest.

SCOPE OF SERVICES

The Consultant will provide all professional services necessary to: inventory current space use, conduct measurements and develop floor plans; conduct needs assessments and develop recommended floor plans and space allocations; analyze costs of occupancy; inspect all facilities to determine conditions and necessary capital improvements; develop standards and procedures for space usage and allocations; based upon the data gathered in the space utilization and facilities condition assessments, develop a long-range plan for real estate usage and management; identify, inventory and classify County-owned parcels not currently utilized for County facilities or operations; develop a disposition plan for excess parcels.

TARGET MILESTONES

- Preliminary Report September 2012
- Final Report May 2013

RECOMMENDED CONSULTANT

- U. S. Equities Realty

ESTIMATED FISCAL IMPACT

- $9,844,265

BOARD APPROVAL REQUEST

SPONSOR: Rhonda Yates, System Director, Pharmacy, CCHHS RY		**EXECUTIVE SPONSOR:** John Cookinham, Interim Chief Financial Officer
DATE: 03/15/2012	**PRODUCT / SERVICE:** Service – DSH/340B Consulting	
TYPE OF REQUEST: Amend Contract	**VENDOR / SUPPLIER:** AmeriSourceBergen Drug Corporation, Valley Forge, PA	
ACCOUNT / FISCAL IMPACT: 890-441 CCHHS NONE		**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 02/01/2012 thru 01/31/2017		**CONTRACT NUMBER:** H08-41-371
	COMPETITIVE SELECTION METHODOLOGY: RFP	
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]**	

PRIOR CONTRACT HISTORY:
The AmeriSourceBergen Drug Corporation currently provides pharmaceutical wholesaler services for Cook County Health and Hospitals System. The existing contract allows for credit for consulting services and software implementation.

NEW PROPOSAL JUSTIFICATION:
The current AmeriSourceBergen contract allows for up to $500K in pharmacy consulting services. These consulting services will be used to assess and improve the CCHHS Disproportionate Share Hospital (DSH) purchasing for 340B designated drugs. Designated drugs are defined as drugs that are provided per HRSA requirements. All of the following must apply for the medication to qualify for 340B pricing: 1) Medication that is provided for outpatient therapy 2) Medication that is provided to patients who are treated in a CCHHS facility, 3) Medication that is dispensed pursuant to a prescription written by a CCHHS-employed physician, or a physician who is contracted ti provide care at a CCHHS facility. These improvements will ensure regulatory compliance, streamline drug expenditures and eliminate waste in the current process.

The current AmeriSourceBergen contract also allows for rebate credit to be utilized for operational purposes. In order to meet DSH/340B regulatory requirements, there is a need to purchase a split billing software package. DSH/340B consulting services will include implementation and training of this software so the CCHHS pharmacy team will be able to fully manage the process independently.

FINANCIAL BENEFIT:
Savings calculation: N/A
Percent: N/A

TERMS OF REQUEST:
This is a request to amend contract number H08-41-371 for a period of 60 months from 02/01/2012 thru 01/31/2017 in the amount of $0 (all expenses will be covered by contract credits).

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE: N/A

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: N/A

Request #
2

DATE: 03/15/2012	**PRODUCT / SERVICE**: Service – DSH/340B Consulting	
TYPE OF REQUEST: Amend Contract	**VENDOR / SUPPLIER**: AmeriSourceBergen Drug Corporation, Valley Forge, PA	
ACCOUNT / 890-441 CCHHS	**FISCAL IMPACT**: NONE	**GRANT FUNDED AMOUNT**: N/A
CONTRACT PERIOD: 02/01/2012 thru 01/31/2017		**CONTRACT NUMBER**: H08-41-371

CCHHS COO: _____
Carol Schneider, System Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

CCHHS CEO: _____
Ram Raju, Chief Executive Officer

BOARD APPROVAL REQUEST

SPONSOR: John Cookinham, Interim Chief Financial Officer, CCHHS		
DATE: 04/12/2012	**PRODUCT / SERVICE:** Service - Professional Services	
TYPE OF REQUEST: Amend Contract	**VENDOR / SUPPLIER:** Kimberly Velasquez, Oak Forest, IL	
ACCOUNT / FISCAL IMPACT: 890-260 $150,000.00		**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 05/01/2012 thru 10/31/2012		**CONTRACT #:** H11-25-123
	COMPETITIVE SELECTION METHODOLOGY: RFP	
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE] Single Feasible Provider**	

PRIOR CONTRACT HISTORY:
Ms. Velasquez was employed by Cook County for 32 years and has facilitated, coordinated and implemented budget adoptions for the last 26 years. Ms. Velasquez retired in October of 2011 and was retained since November 1, 2011 to assist the Interim Chief Financial Officer with the preparation of the CCHHS FY 2012 Budget. The terms of her current contract expire on April 30, 2012.

NEW PROPOSAL JUSTIFICATION:
This request is for Ms. Velasquez to assist the Interim Chief Financial Officer with the preparation of the CCHHS FY 2013 Budget which shall include the preparation and generation of reports, gathering of data, computation of amounts to be included in budget entries, entry of data into the financial management information system and Budget Request (BR) system and attendance and presentation at meetings as requests. The scope of services will also include training and transition of the new Budget Director once they are hired.

FINANCIAL BENEFIT:
Savings calculation: NA
Percent: NA

TERMS OF REQUEST:
This is a request to amend contract number H11-25-123 for a period of six (6) months from 05/01/2012 thru 11/01/2012 in an amount not to exceed $150,000.00.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE: N/A

ATTACHMENTS
BID TABULATIONS: NA
CONTRACT COMPLIANCE MEMO: N/A

CCHHS COO:_____
Carol Schneider, System Chief Operating Officer

CCHHS CFO:_____
John Cookinham, Interim Chief Financial Officer

CCHHS CEO:_____
Dr. Ram Raju, Chief Executive Officer

Request # 3

BOARD APPROVAL REQUEST

SPONSOR: Ram Raju Chief Executive Officer			
DATE: April 4, 2012		**PRODUCT / SERVICE**: Service – Professional Services	
TYPE OF REQUEST: Extend, Amend and Increase Contract		**VENDOR / SUPPLIER**: Health Management Associates (HMA), Chicago, Illinois	
FISCAL IMPACT: 890-260 Account	$509,250	**GRANT FUNDED AMOUNT**: NA	
CONTRACT PERIOD: December 1, 2011 through November 30, 2013		**CONTRACT #**: 07-45-307	
	COMPETITIVE SELECTION METHODOLOGY:		
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]**		

PRIOR CONTRACT HISTORY:

Health Management Associates has provided CCHHS with specialized technical assistance related to Medicaid reimbursement for the past several years. The current contract provides consulting services focusing on Medicaid cost reporting, reimbursement, policy issues and future planning regarding the Affordable Care Act.

NEW PROPOSAL JUSTIFICATION:

This request is to extend, amend and increase the contract with Health Management Associates in the amount of $509,250 to provide for additional services with respect to future planning regarding patient centered medical homes. HMA has lent critical guidance in the development of the 1115 Waiver application and CCHHS is in need of their services with the development and implementation of a care coordination model that consists of the full continuum of patient care. HMA's expertise in clinical approaches to disease management and specialty care organizations has been demonstrated across the country in other public hospital systems and their in-depth knowledge of CCHHS makes them uniquely qualified to best provide these services.

FINANCIAL BENEFIT:
Savings calculation: NA
Percent: NA

TERMS OF REQUEST: This is a request to amend and increase Contract No. 07-45-307 in the amount of $509,250.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE: Review Pending

ATTACHMENTS
BID TABULATIONS:
CONTRACT COMPLIANCE MEMO:

CCHHS COO: _____
Carol Schneider, Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

Request #
4

BOARD APPROVAL REQUEST

SPONSOR: Tanda Russell, Interim System Chief Nursing Officer, CCHHS		**EXECUTIVE SPONSOR:**	
DATE: 03/21/2012	**PRODUCT / SERVICE:** Product - Urological Supplies		
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** Boston Scientific, Natick, MA 01760		
ACCOUNT / FISCAL IMPACT: 897-1496 Stroger Hospital $797,366.00		**GRANT FUNDED AMOUNT:** N/A	
CONTRACT PERIOD: 05/01/2012 thru 04/30/2014		**CONTRACT NUMBER:** H12-25-029	
X	**COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO / OMP]** GPO, Novation Contract # MS01173		
	NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE] N/A		

PRIOR CONTRACT HISTORY:
Prior direct contract number 04-45-804 ended in 2008. Since then Boston Scientific Urology products have been purchased through Owens and Minor.

NEW PROPOSAL JUSTIFICATION:
This contract will provide for urological supplies in the surgery department. These are clinically necessary items for the urology service line. Products have been reviewed by the overall Surgical Value Analysis team and a Urology sub-team. These products include urological stents, lithoclast disposables, back stops, sheaths, catheters, etc.

FINANCIAL BENEFIT: [Prior Cost versus New Cost]
Savings calculation: $58,768.05 over 24 months
Percent: 7%

TERMS OF REQUEST:
This is a request to execute contract number H12-25-029 for a period of 24 months from 05/01/2012 thru 04/30/2014 in the amount of $797,366.00.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: Pending

CCHHS COO: _____
Carol Schneider, System Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

CCHHSCEO: _____
Ram Raju, Chief Executive Officer

Request # 5

BOARD APPROVAL REQUEST

SPONSOR: Patrick Dunne, M.D., Chairman Radiology, CCHHS	**EXECUTIVE SPONSOR:** Carol Schneider, System Chief Operating Officer, CCHHS
DATE: 03/20/2012	**PRODUCT / SERVICE:** Computed Tomography (CT) Syringes
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** Medrad Inc., Warrendale, PA
ACCOUNT / FISCAL IMPACT: 897-033 Stroger Hospital $484,145.00 898-212 Oak Forest Health Center $70,750.00 891-367 Provident Hospital $90,000.00 Total: $644,895.00	**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 05/01/2012 thru 04/30/2013	**CONTRACT #:** H12-73-026
X	**COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO / OMP]** GPO, Novation Contract XR0042
	NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]

PRIOR CONTRACT HISTORY:
Previous contract number H09-73-172 for CT Scanner syringes expired 09/23/2010. Previous contract number H10-73-022 for CT syringes for new 64 slice CT expired 07/08/2011. Stroger Hospital acquired one 64 slice CT on lease in 2011. Prior Medrad Novation contract XR90010 for all CT syringes expired 09/30/2011.

NEW PROPOSAL JUSTIFICATION:
Syringes need to be purchased to perform CT, MRI, and Angiography exams at Stroger Hospital, Oak Forest Health Center, and Provident Hospital.

FINANCIAL BENEFIT: [Prior Cost versus New Cost]
Savings calculation: $119,683.40
Percent: 18%

TERMS OF REQUEST:
This is a request for a one year contract number H12-73-026 to provide syringes for power injectors in CT, MRI, and Angiography from 05/01/2012 thru 04/30/2013 in the amount of $644,895.00

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: Pending

CCHHS COO: _____
Carol Schneider, System Chief Operating Officer

CHHS CFO: _____ For John Cookinham
John Cookinham, Interim Chief Financial Officer

CCHHS CEO: _____
Ram Raju, Chief Executive Officer

Request #
6

AS AMENDED

BOARD APPROVAL REQUEST

SPONSOR: Daniel J. Howard, Chief Information Officer, CCHHS Donna Hart, Director of Financial Systems, CCHHS		**EXECUTIVE SPONSOR:**
DATE: 03/19/2012	**PRODUCT / SERVICE:** SAP Licenses, Wireless Access Points, UPS Batteries	
TYPE OF REQUEST: Purchase **Execute Contract**	**VENDOR / SUPPLIER:** CDW-G, Vernon Hills, Illinois	
ACCOUNT /FISCAL IMPACT: 890-0601 $566,698.19		**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: One Time Contract Effective 05/01/2012		**CONTRACT NUMBER:** H12-25-021
X	**COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO]** GPO	
	NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]	

PRIOR CONTRACT HISTORY:
This is a new contract to purchase 3 additional SAP Licenses, 57 UPS Batteries, and 50 Wireless Access Points from CDW-G through GPO.

NEW PROPOSAL JUSTIFICATION:
The additional SAP Licenses are required due to increased utilization within Cerner Power Insight, and Siemens DSS, which are clinical and financial warehouses. The functionality queries data from both finance and clinical systems to extract and report data for leadership of this organization and to outside regulatory agencies.

UPS Batteries are needed for electric protection of the new Cisco network equipment installed in the Stroger Hospital during the last quarter of 2011. It is imperative that the network equipment remain protected at all times for ensured functionality, failure prevention, and compliance with our service agreement.

Wireless Access Points are necessary to complete the wireless upgrade project started in 2011. The units in the Hektoen, Administration and Provident Hospital buildings will be deployed to replace the existing wireless infrastructure, which has fallen out of support and is at end of life.

FINANCIAL BENEFIT: (Prior Cost versus New Cost)
Savings Calculation: NA
Percent: N/A

TERMS OF REQUEST:
This is request for contract number H12-25-021 to purchase SAP Licenses, UPS Batteries, as well as Wireless Access Points. This is a one time purchase of $566,698.19.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

ATTACHMENTS
VENDOR QUOTE: Yes
CONTRACT COMPLIANCE MEMO: Pending

Request #
7

DATE: 03/19/2012	PRODUCT / SERVICE: SAP Licenses, Wireless Access Points, UPS Batteries
TYPE OF REQUEST: Purchase	VENDOR / SUPPLIER: CDW-G, Vernon Hills, Illinois
ACCOUNT / FISCAL IMPACT: 890-0601 $566,698.19	GRANT FUNDED AMOUNT: N/A
CONTRACT PERIOD: One Time Contract Effective 05/01/2012	CONTRACT # H12-25-021

CCHHS COO:_____
Carol Schneider, System Chief Operating Officer

CCHHS CFO:_____
John Cookinham, Interim Chief Financial Officer

CCHHS CEO:_____
Ram Raju, Chief Executive Officer

BOARD APPROVAL REQUEST

SPONSOR: Tanda Russell, Interim System Chief Nursing Officer, CCHHS	**EXECUTIVE SPONSOR:**
DATE: 03/29/2012	**PRODUCT / SERVICE:** Product – Vascular Tissue
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** W. L. Gore & Associates, Inc., Newark, Delaware 19711
ACCOUNT / FISCAL IMPACT: 897-0247 Stroger Hospital $400,000.00	**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 05/01/2012 thru 04/30/2013	**CONTRACT NUMBER::** H11-73-032
X	**COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO / OMP]** GPO vendor, GPO Contracts: MS80753 and MS01124
	NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]

PRIOR CONTRACT HISTORY:
H09-41-151 Expired 7/31/2011.

NEW PROPOSAL JUSTIFICATION:
This contract will provide for vascular tissue supplies and accessories. These tissue supplies are used by the Cardiothoracic and Vascular surgeons. The grafts are required to perform vascular and hernia repair surgeries.

These specific vascular tissue supplies and accessories are manufactured and distributed by W. L. Gore & Associates, Inc. The Value Analysis team met with the surgery physicians and they determined that these supplies from W.L. Gore are clinically necessary.

FINANCIAL BENEFIT: [Prior Cost versus New Cost]
Savings calculation: N/A
Percent: N/A

TERMS OF REQUEST:
This is a request to execute contract number H11-73-032 for a period of 12 months from 05/01/2012 thru 04/30/2013 in the amount of $400,000.00.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Yes

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: Yes

CCHHS COO: _____
Carol Schneider, Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

CCHHS CEO: _____
Ram Raju, Chief Executive Officer

Request # 8

COOK COUNTY
OFFICE OF CONTRACT COMPLIANCE

LAVERNE HALL
DIRECTOR

118 North Clark Street, Room 1020
Chicago, Illinois 60602-1304
TEL (312) 603-5502
FAX (312) 603-4547

April 16, 2012

Ms. Girvena LeBlanc, BA, MPA
Supply Chain Management
Procurement Department
John H. Stroger, Jr. Hospital
1969 W. Ogden Avenue, LL250
Chicago, IL 60612

Re: Contract No. H11-73-032

Dear Ms. LeBlanc:

The following bid for the above referenced contract has been reviewed for compliance with the General Conditions regarding the Minority and Woman Business Enterprises Ordinance and has been found to be responsive to the Ordinance.

Bidder: W.L. Gore & Associates, Inc., Newark, DE (Revised)
Bid Amount: $400,000.00

Waiver Granted:
W.L. Gore & Associates, Inc. is the sole manufacturer and distributer of vascular Tissue Supplies.

The Office of Contract Compliance has been advised that no other bidders are being recommended for award.

Sincerely,

LaVerne Hall
Director

LH/lar

BOARD APPROVAL REQUEST

SPONSOR: David Lai, AIA, LEED AP, Director of Stroger Hospital Plant Jim DeLisa, System Director Plant Operations, CCHHS	**EXECUTIVE SPONSOR:** Carol Schneider, System Chief Operating Officer, CCHHS
DATE: 03/16/2012	**PRODUCT / SERVICE:** Services and Supplies: Pneumatic Tube System Maintenance Services, Supplies and System Upgrade
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** Translogic Corporation dba Swisslog Healthcare, Denver, Colorado
ACCOUNT / FISCAL IMPACT: 879-449 Stroger Hospital $352,000.00	**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 05/15/2012 thru 05/14/2015	**CONTRACT NUMBER:** H12-72-028

	COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO / OMP]
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]**

PRIOR CONTRACT HISTORY:
The previous contract was a Sole Source awarded for a thirty-six (36) month period which expires on May 14, 2012.

NEW PROPOSAL JUSTIFICATION:
The existing pneumatic tube system is owned by the hospital. This is proprietary software and hardware which can only be upgraded and maintained by Translogic Corporation, the original manufacturer. This request is required to support the upgrade of the system and the monthly maintenance services and supplies.

FINANCIAL BENEFIT:
Savings calculation or Cost avoidance calculation: N/A
Percent: N/A

TERMS OF REQUEST:
This is a request to execute on a sole source basis, contract number H12-72-028 for a period of thirty-six (36) months from 05/15/2012 thru 05/14/2015 in the amount of $352,000.00.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE? Pending

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: Pending

CCHHS COO: _____
Carol Schneider, System Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

Request # 9

DATE: 03/16/2012	PRODUCT / SERVICE: Services and Supplies: Pneumatic Tube System Maintenance Services, Supplies and System Upgrade
TYPE OF REQUEST: Execute Contract	VENDOR / SUPPLIER: Translogic Corporation dba Swisslog Healthcare, Denver, Colorado
ACCOUNT / FISCAL IMPACT: 879-449 Stroger Hospital $352,000.00	GRANT FUNDED AMOUNT: N/A
CONTRACT PERIOD: 05/15/2012 thru 05/14/2015	CONTRACT NUMBER: H12-72-028

CCHHS CEO:_____
Ram Raju, Chief Executive Officer

AS AMENDED

BOARD APPROVAL REQUEST

SPONSOR: Clifton Clarke, Chairman, Department of Internal Medicine, Provident Hospital, CCHHS Tom Dohm, Interim Chief Operating Officer, Provident Hospital, CCHHS	**EXECUTIVE SPONSOR:** Carol Schneider, Chief Operating Officer, CCHHS
DATE: 03/12/2012	**PRODUCT / SERVICE:** Product – Endoscopes, Colonoscopes Image Management System
TYPE OF REQUEST: Replacement One time Purchase **Execute Contract**	**VENDOR / SUPPLIER**: Olympus Anesthesia – Endoscope Division.
ACCOUNT / FISCAL IMPACT 717-891 Provident Hospital $258,414.77	**GRANT FUNDED AMOUNT**: N/A
CONTRACT PERIOD: One Time Purchase	**CONTRACT NUMBER**: H12-76-032

	COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO] N/A
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]**

PRIOR CONTRACT HISTORY:
The Divisions of Gastroenterology, ENT, General Surgery, Thoracic Surgery, and Pulmonary and Critical Care Medicine at Stroger Hospital have all purchased equipment for use at Stroger Hospital from Olympus America, Inc. The most recent purchase was completed in 2010. Olympus is our system wide platform for endoscopic equipment and shares common software, servers, and IT interfaces with the Cerner System.

NEW PROPOSAL JUSTIFICATION:
The Division of Internal Medicine is requesting to purchase an Olympus Evis Exera II High Definition Endoscopic and Colonoscope System. The flexibility of this system will allow for a common platform to be used for endoscopic evaluation of gastric, duodenal, and large and small intestinal pathology. It also permits interventions and diagnostic biopsies as required. The Evis Exera II Colonoscopy provides an exclusive extra-wide 170° field of view, which will improve diagnostic performance and reduce examination time, thereby increasing efficiency. This equipment will improve the services and care for the patients treated at Provident Hospital.

Olympus is our system wide platform for endoscopic equipment and shares common software, servers, and IT interfaces with the Cerner System.

FINANCIAL BENEFIT: (Prior Cost versus New Cost)
Savings calculation: NA
Percent: N/A

TERMS OF REQUEST:
This capital purchase is being funded from the capital budget approved 07/27/2011. The funding is coming from 2 items from 2009 ($85,000.00) and 3 items from 2010 ($180,000.00). The difference in dollars is the budgeted amount versus the actual purchase price. This is a request to execute contract number H12-76-032, a one time purchase of an Endoscopes and Colonoscopes Image Management System in the amount $258,414.77.

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE: yes

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: yes

Request #
10

DATE: 03/12/2012	PRODUCT / SERVICE: Product – Endoscopes, Colonoscopes Image Management System
TYPE OF REQUEST: Replacement One time Purchase	VENDOR / SUPPLIER: Olympus Anesthesia – Endoscope Division.
ACCOUNT / FISCAL IMPACT 717-891 Provident Hospital $258,414.77	GRANT FUNDED AMOUNT: N/A
CONTRACT PERIOD: One Time Purchase	CONTRACT NUMBER: H12-76-032

CCHHS COO:_____
Carol Schneider, System Chief Operating Officer

CCHHS CFO:_____
John Cookinham, Interim Chief Financial Officer

CCHHS CEO:_____
Ram Raju, Chief Executive Officer

BOARD APPROVAL REQUEST

SPONSOR: Joanne Dulski, Director of Pathology, CCHHS		**EXECUTIVE SPONSOR:** Carol Schneider, System Chief Operating Officer, CCHHS
DATE: 03/09/2012	**PRODUCT / SERVICE:** Service – Renal Biopsy Consultations	
TYPE OF REQUEST: Execute Contract	**VENDOR / SUPPLIER:** Rush Medical Laboratories, Chicago, Illinois	
ACCOUNT / FISCAL IMPACT: 897-278 Stroger Hospital $156,278.00		**GRANT FUNDED AMOUNT:** N/A
CONTRACT PERIOD: 05/01/2012 thru 04/30/2013		**CONTRACT NUMBER:** H11-73-108
	COMPETITIVE SELECTION METHODOLOGY: [BID / RFP / GPO] N/A	
X	**NON-COMPETITIVE SELECTION METHODOLOGY: [SOLE SOURCE]** Single Feasible Provider	

PRIOR CONTRACT HISTORY:
The current contract number H08-41-273 was approved by the Cook County Health and Hospitals System Board on 04/30/2010 for 24 months from 05/01/2010 thru 04/30/2012 in the amount $263,760.00.

NEW PROPOSAL JUSTIFICATION:
This proposal is to execute contract number H11-73-108 for 12 months from 05/01/2012 thru 04/30/2013 based on the previous month's utilization. Renal biopsies are performed for clinical diagnoses purposes. Rush Medical Laboratories has the expertise and resources to perform them, of which the Department of Pathology at Stroger does not.

TERMS OF REQUEST:
There were 79 renal biopsy cases in 2011 that were $1978.20 each. Renal biopsies consist of 4 tests. This request is to execute contract number H11-73-108 for 12 months from 05/01/2012 thru 04/30/2013 in the amount of $156,278.00.

FINANCIAL BENEFIT: (Prior Cost versus New Cost)
Savings calculation: NA
Percent: N/A

CONTRACT COMPLIANCE HAS FOUND THIS CONTRACT RESPONSIVE: Yes

ATTACHMENTS
BID TABULATIONS: N/A
CONTRACT COMPLIANCE MEMO: Yes

CCHHS COO: _____
Carol Schneider, System Chief Operating Officer

CCHHS CFO: _____
John Cookinham, Interim Chief Financial Officer

Request #
11

DATE: 03/09/2012	PRODUCT / SERVICE: Service – Renal Biopsy Consultations
TYPE OF REQUEST: Execute Contract	VENDOR / SUPPLIER: Rush Medical Laboratories, Chicago, Illinois
ACCOUNT / FISCAL IMPACT: 897-278 Stroger Hospital $156,278.00	GRANT FUNDED AMOUNT: N/A
CONTRACT PERIOD: 05/01/2012 thru 04/30/2013	CONTRACT NUMBER: H11-73-108

CCHHS CEO:_____
Ram Raju, Chief Executive Officer

COOK COUNTY
OFFICE OF CONTRACT COMPLIANCE

LAVERNE HALL
DIRECTOR

118 North Clark Street, Room 1020
Chicago, Illinois 60602-1304
TEL (312) 603-5502
FAX (312) 603-4547

December 5, 2011

Ms. Girvena LeBlanc
Supply Chain Management
& Procurement Department
John H. Stroger, Jr. Hospital
1901 West Harrison Street, LL250
Chicago, IL 60612

Re: Contract No. H11-73-108

Dear Ms. LeBlanc:

The following bid for the above referenced contract has been reviewed for compliance with the General Conditions regarding the Minority and Women Owned Business Enterprises Ordinance and has been found to be responsive to the Ordinance:

Contractor:	Rush University Medical Center Laboratories, not for profit organization
Contract Amount:	$400,000.00
Description:	Services – Clinical Consulting, Renal Biopsy

WAIVER GRANTED

The Office of Contract Compliance has determined that it is in the best interest of CCHHS to award this contract.

Sincerely,

LaVerne Hall
Contract Compliance Administrator

LH/pgb

ATTACHMENT #2

Cook County Health and Hospitals System

Financial Statements

Year To Date February 29, 2012

As of April 16, 2012

Index **Page**

COOK COUNTY HEALTH & HOSPITALS SYSTEM

MISSION STATEMENT

The Cook County Health and Hospitals System will deliver integrated health services with dignity and respect regardless of a patient's ability to pay; and,

Foster partnerships with other health providers and communities to enhance the health of the public; and,

Advocate for policies, which promote and protect the physical, mental and social well being of the people of Cook County.

Board of Directors
Cook County Health and Hospitals System

The accompanying financial statement of Cook County Health and Hospitals System and the related Management's Discussion and Analysis for the month ended February 29, 2012 have been prepared by Management who is responsible for their presentation and disclosure. The statement have not been compiled, reviewed or audited by independent accountants.

CCHHS maintains an internal control structure designed to provide reasonable assurance that assets are safeguarded and that transactions are properly executed, recorded and summarized to produce reliable records and reports,

To the best of Management's knowledge and belief the statements were prepared in conformity with generally accepted accounting principles and governmental accounting standards using the accrual basis of accounting and are based on recorded transactions and Management's best estimates and judgment.

John Cookinham, Interim Chief Financial Officer _____

Dorothy M. Loving, Executive Director of Finance _____

MANAGEMENT'S DISCUSSION AND ANALYSIS

INTRODUCTION

This discussion and analysis provides the readers of the monthly unaudited financial statements of the Cook County Health and Hospital System (CCHHS) with an overview of the financial activities and financial activities for the month ended February 29, 2012. This discussion focuses on the significant financial issues and major financial activities during the current month. It should be read in conjunction with the accompanying financial statements of the CCHHS.

The CCHHS includes the following entities: John H. Stroger Jr. Hospital (JSH), Oak Forest Health Center (OFC) Provident Hospital (PHCC), the Department of Public Health (DPH), the Ambulatory and Community Health Network (ACHN), the Bureau of Health Services (BHS), CORE Center (for reporting purposes part of Stroger Hospital), and Cermak Health Services (CHS). Collectively, these entities provide primary, intermediate, acute, and tertiary medical care to patients, without regard to their ability to pay. The Bureau of Health Services oversees the operational, planning, and policy activities of the CCHHS.

The CCHHS is included in the reporting entity of the Cook County, Illinois, as an enterprise fund. As an enterprise fund, the CCHHS' financial statements are prepared using proprietary fund accounting that focuses on the determination of changes in net assets, financial position, and cash flows in a manner similar to private sector businesses. The financial statements are prepared on an accrual basis of accounting, which recognizes revenue when earned and expenses when incurred.

In 2008 the Cook County Health and Hospital System Board was created by the Cook County Board of Commissioners to provide independent oversight of health care operations, and in 2010 the Cook County Board of Commissioners voted to make the Cook County Health and Hospital System Board permanent.

In 2010 the Cook County Health and Hospital System Board and the Cook County Board of Commissioners approved Vision 2015 Strategic Plan, which outlines, over five years, restructuring CCHHS to deliver the best possible care for the vulnerable population of Cook County within the constraints of dollar resources available to the health system. This plan seeks to better allocate resources.

FINANCIAL HIGHLIGHTS (IN THOUSANDS)

The Cook County Health and Hospitals System finished the three months with overall revenue of $247,238 and overall expenses was $220,739.

Net Patient revenue for the three months was $174,948.

Net Patient revenue consists of all charges including automated contractual allowances and bad debt adjustments. Write-off of Bad Debt is a CCHHS Board approved policy.

Other revenue was $1,027. Other revenue consists primarily of parking revenue.

Patient Accounts Receivable – BEPA System Only

General

As compared to November 30, 2011, Total Patient Accounts Receivable at the end of February-2012 increased by 23 days of revenue (or 14.9%). There were 154 days of revenue (charges) outstanding at November 30, 2011 and 177 days outstanding at the end of February-2012. The increase in this figure is due in part to the fact that the internal bill hold on Out-Patient accounts was reduced from 20 days to 6 days and in part to the fact that billed accounts grew by $85.411M (24.1%).

Days of Revenue Outstanding measures the average number of days charges remain in accounts receivable after service has been rendered before collection activities have been completed, including charity care and bad debt write-offs. Days of Revenue Outstanding is measured in charges, not cash collections.

Days of Revenue Outstanding is a useful tool to measure collection efforts over time (i.e., whether this number is growing or decreasing). This number will be large due to the large number of Self-Pay patients CCHHS services and the processes CCHHS must complete before patient accounts are collected or written-off to bad debt. These processes include, but are not limited to, the following:

- Making an effort to attain third-party insurance coverage;
- Processing charity care applications;
- Sending three (3) monthly statements before accounts are turned over to collections;
- Providing the collection agencies the necessary time to perform their collection services; and
- Permitting patients to pay their account balances over time (time payment).

Inpatient Accounts Receivable – BEPA System Only

Discharged Not Final Billed

Inpatient discharged but not final billed accounts at the end of February-2012 decreased by $10.890M (51.4%) as compared the November 30, 2011 balance. This amount is also less than the previous month's balance by $2.509M (19.6%). These items taken together indicate an increasing number of accounts are moving to a "Billed" status.

The change in this figure does not translate dollar-for-dollar into actual cash receipts, as Medicaid pays CCHHS claims on a per-diem and Medicare pays CCHHS on the diagnosis, regardless of charges on the patient accounts. Additionally, charity care and bad debt write-offs will not result in actual cash collections.

Billed Inpatient Accounts

Billed inpatient accounts at the end of February-2012 increased by $53.761M (or 27.9%). This amount exceeds the previous month's balance by $19.992M (8.8%). This increase also increased CCHHS' days in revenue outstanding.

The increase in this number indicates more accounts are waiting for the collection process to conclude. CCHHS' collection process includes charity care and bad debt write-offs. $10.890M of this increase was due to the decrease in Discharged Not Final Billed. This increase also increased CCHHS' days in revenue outstanding.

The change in this figure does not translate dollar-for-dollar into actual cash receipts, as Medicaid pays on a per-diem and Medicare pays on the diagnosis, regardless of charges on the patient accounts. Additionally, charity care and bad debt write-offs will not result in actual cash collections.

$3.018M In-Patient accounts were written-off to charity care during February-2012, bringing the fiscal year's total to $8.249M.

Outpatient Accounts Receivable – BEPA System Only

Unbilled Outpatient Accounts

The balance of unbilled outpatient accounts decreased by $0.674M (3.0%) by the end of February-2012, as compared to the level of unbilled accounts as of November 30, 2011. The change in this figure indicates more patient bills were moved to a "Billed" status, as compared to November 30, 2011. Part of the increase in this figure is due the reduction of the internal bill hold from 20 days to 6 days.

The change in this figure does not translate dollar-for-dollar into actual cash receipts due to Medicaid and Medicare's reimbursement configuration.

Billed Outpatient Accounts

The billed outpatient accounts receivable at the end of February-2012 rose by $31.650M (19.6%) over the balance as of November 30, 2011. This figure is also greater than the previous month's balance by $13.692M (7.6%).

The growth in this figure indicates a greater number of Out-Patient accounts were moved to a "Billed" status and a reduced number of Out-Patient accounts had collection and write-off related activities completed as compared to November 30, 2011. Part of this increase is due to the fact that the internal bill hold on Out-Patient accounts was reduced to 6 days.

The change in this figure does not translate dollar-for-dollar into actual cash receipts due to Medicaid and Medicare's reimbursement configuration and to charity care and bad debt write-offs.

$15.086M Out-Patient accounts were written-off to charity care during February-2012, bringing the fiscal year's total to $42.890M.

Operating Expenses at the end of three months was $220.739M broken down as follows:

Salaries and Wages - $121.891M

Benefits - $35.618M

Supplies - $19.656M

Purchased Services, Rental, and Other - $24.579M

Depreciation - $8.361M

Utilities - $992

Insurance - $9.643M

Nonoperating Revenue was $71.263M. The largest portions of this are attributed to sales tax in the amount of $33.593M and property tax in the amount of $20.021M.
Sales tax revenues are recognized by CCHHS when earned; this occurs when the underlying sales transactions occur. The amount recorded as *Due from State of Illinois - Sales Tax* represents the amounts earned by CCHHS, however, the cash is not yet received from the state. There is a 3 months lag from the time of the underlying sales transaction to the receipt of funds.
Taxes collected for the Health to date have been fully credited to the Health Fund except as mentioned in the previous paragraph.

OVERVIEW OF THE FINANCIAL STATEMENTS

This discussion and analysis are intended to serve as an introduction to the CCHHS financial statements. CCHHS basic monthly unaudited financial statements are comprised of fund financial statements.

A fund is a grouping of related accounts that is used to maintain control over resources that have been segregated for specific activities or objectives. The CCHHS, like other state and local governments, uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements.

Accounts Receivable Comparison
Cook County Health and Hospitals System
Fiscal 2012

	12/31/2011 BEPA	1/31/2012 BEPA	2/29/2012 BEPA
Inpatient			
In-house	$ 12,795,759.00	$ 13,552,149.00	$ 13,699,833.00
Discharged Not Final Billed	$ 16,039,995.00	$ 12,807,580.00	$ 10,298,697.00
Billed	$ 215,372,795.90	$ 226,684,054.84	$ 246,676,173.25
Total Inpatient Asccounts Receivable	**$ 244,208,549.90**	**$ 253,043,783.84**	**$ 270,674,703.25**
Outpatient			
Unbilled	$ 22,386,168.48	$ 23,355,904.97	$ 21,675,530.97
Billed	$ 172,222,205.52	$ 179,257,581.03	$ 192,949,670.03
Total Outpatient Accounts Receivable	**$ 194,608,374.00**	**$ 202,613,486.00**	**$ 214,625,201.00**
Combined Inpatient and Outpatient A/R			
Unbilled	$ 51,221,922.48	$ 49,715,633.97	$ 45,674,060.97
Billed	$ 387,595,001.42	$ 405,941,635.87	$ 439,625,843.28
Total IP and OP Accounts Receivable	**$ 438,816,923.90**	**$ 455,657,269.84**	**$ 485,299,904.25**
Average Daily Revenue	**$ 2,566,742.00**	**$ 2,582,261.00**	**$ 2,748,845.00**
Days of Revenue Outstanding	**171**	**176**	**177**

Cook County Health Facilities
Combining Balance Sheet of General Funds (Unaudited)
(In Thousands)
February 29, 2012

	Stroger Hospital	ACHN (Clinics)	Total Stroger & ACHN	O F C (Oak Forest)	Provident Hospital	Bureau of Health	Hospitals Total	Dept of Public Health	Cermak	Intra-Activity Eliminations	Grand Total
ASSETS											
CURRENT ASSETS:											
Cash and cash equivalents:											
Cash in banks	1,360	1	1,361	101	154		1,616	0			1,616
Cash held by Cook Co Treas	473,346		473,346	76,037	118,207	200	667,789	104,616		(772,405)	
Due from working cash fund	60,124	34,607	94,732				94,732			(51,761)	42,971
Total cash & cash equivalent	534,830	34,608	569,438	76,137	118,361	200	764,137	104,616		(824,166)	44,587
Property taxes receivable:											
Tax levy - current year	38,977	46,319	85,296	7,319	7,009	3,967	103,592	11,304			114,895
Tax levy - prior year	9,637	9,850	19,487	1,937	2,062	865	24,351	2,690			27,041
Total property taxes rec	48,614	56,169	104,783	9,257	9,071	4,832	127,943	13,993			141,936
Receivables:											
Patient AR-net of allowances	103,857		103,857	4,466	15,815		124,138				124,138
Third-party settlements	7,201		7,201	23	65		7,289				7,289
Other receivables	780	6	786	7	14	1	808	164	1		974
Due from State - sales taxes	7,977	8,788	16,765	2,363	3,849	764	23,742	3,232	6,619		33,593
Interacct (payable)receivabl	(138,985)		(138,985)	10,430	(25,567)	155,656	1,534	(2)	(1,532)		
Total receivables	(19,169)	8,794	(10,375)	17,288	(5,824)	156,421	157,510	3,394	5,089		165,993
Inventories	4,166		4,166	175	1,210		5,551		303		5,853
TOTAL CURRENT ASSETS	568,442	99,571	668,013	102,857	122,818	161,453	1,055,141	122,003	5,392	(824,166)	358,370
CAPITAL ASSETS:											
Depreciable assets - net	375,538	6,946	382,484	27,004	21,130	14,121	444,738	2,320	689		447,746
TOTAL ASSETS	943,980	106,517	1,050,497	129,861	143,947	175,574	1,499,879	124,323	6,080	(824,166)	806,116

Cook County Health Facilities
Combining Balance Sheet of General Funds (Unaudited)
(In Thousands)
February 29, 2012

	Stroger Hospital	ACHN (Clinics)	Total Stroger & ACHN	O F C (Oak Forest)	Provident Hospital	Bureau of Health	Hospitals Total	Dept of Public Health	Cermak	Intra-Activity Eliminations	Grand Total
LIABILITIES & NET ASSETS											
CURRENT LIABILITIES:											
Due to Cook County Treasurer		166,668	166,668			636,679	803,347		20,818	(824,166)	
Accounts payable	15,119	273	15,391	911	2,592	10,886	29,779	406	217		30,402
Accrued salaries, wages, & other liabilities	2,473	321	2,794	215	374	333	3,716	(27)	282		3,970
Compensated absences	25,580	3,019	28,599	2,143	3,717	3,544	38,002	1,175	2,575		41,752
Deferred revenues	48,546		48,546	10,848	9,472		68,866				68,866
Due to others				11			11				11
TOTAL CURRENT LIABILITIES	91,717	170,281	261,999	14,128	16,154	651,441	943,722	1,554	23,892	(824,166)	145,002
LONG-TERM LIABILITIES:											
Reserve-tax objection suits	4,254	2,540	6,795	1,016	1,307	247	9,364	1,081			10,446
TOTAL LIABILITIES	95,972	172,822	268,793	15,144	17,460	651,688	953,086	2,635	23,892	(824,166)	155,447
NET ASSETS:											
Investment in capital assets	375,538	6,946	382,484	27,004	21,130	14,121	444,738	2,320	689		447,746
Beginning balance	445,875	(102,748)	343,127	88,235	92,516	(459,880)	63,998	117,160	(13,095)		168,063
Bond depreciation	5,949	212	6,160	720	616	817	8,313	7	41		8,361
Excess revenue (expenses)	20,647	29,285	49,932	(1,243)	12,225	(31,172)	29,743	2,201	(5,446)		26,499
Ending balance	848,008	(66,305)	781,703	114,717	126,487	(476,114)	546,793	121,688	(17,812)		650,669
TOTAL LIABILITIES & NET ASSETS	943,980	106,517	1,050,497	129,861	143,947	175,574	1,499,879	124,323	6,080	(824,166)	806,116

Cook County Health Facilities
Combining Income Statement of General Funds (Unaudited)
(In Thousands)
February 29, 2012

	Stroger Hospital	ACHN (Clinics)	Total Stroger & ACHN	O F C (Oak Forest)	Provident Hospital	Bureau of Health	Hospitals Total	Dept of Public Health	Cermak	Grand Total
REVENUE:										
Net patient service revenue	117,160	32,088	149,248	4,395	21,305		174,948	0		174,948
Other revenue	533	267	801	110	63		974	53	0	1,027
Total Revenue:	117,694	32,355	150,048	4,505	21,368		175,922	53	0	175,975
OPERATING EXPENSES:										
Salaries and wages	76,147	9,565	85,712	5,584	8,567	10,321	110,184	2,249	9,458	121,891
Employee benefits	21,381	2,942	24,323	1,978	2,624	3,176	32,100	909	2,609	35,618
Supplies	1,562	7,205	8,766	227	242	10,409	19,645	11	0	19,656
Purchased svs, rental & other	11,131	1,317	12,448	598	2,403	8,504	23,953	265	360	24,579
Depreciation	5,949	212	6,160	720	616	817	8,313	7	41	8,361
Utilities	568	11	579	179	203		961	31		992
Insurance expense	5,222	708	5,929	1,212	937	676	8,754	225	664	9,643
TOTAL OPERATING EXPENSES	121,959	21,959	143,918	10,499	15,592	33,903	203,911	3,697	13,131	220,739
GAIN (LOSS) FROM OPERATIONS	(4,266)	10,396	6,130	(5,993)	5,776	(33,903)	(27,990)	(3,644)	(13,131)	(44,765)
NONOPERATING REVENUE:										
Property taxes	6,759	8,148	14,907	1,259	1,191	697	18,054	1,967		20,021
Cigarette taxes	1,202	717	1,919	287	369	70	2,644	305		2,949
Sales taxes	7,977	8,788	16,765	2,363	3,849	764	23,742	3,232	6,619	33,593
Interest income	2		2	0	0		2			2
Retirement plan contribution	8,973	1,236	10,209	841	1,041	1,201	13,291	341	1,065	14,698
TOTAL NONOPERATING REVENUE	24,913	18,890	43,802	4,751	6,449	2,731	57,733	5,845	7,685	71,263
NET INCOME (LOSS)	20,647	29,285	49,932	(1,243)	12,225	(31,172)	29,743	2,201	(5,446)	26,499

Cook County Health Facilities
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	124,351	50,597	174,948
Other revenue	712	315	1,027
Total Revenue	125,063	50,912	175,975
OPERATING EXPENSES:			
Salaries and wages	81,639	40,252	121,891
Employee benefits	22,652	12,966	35,618
Supplies	10,696	8,960	19,656
Purchased svs, rental & other	13,698	10,881	24,579
Depreciation	5,334	3,027	8,361
Insurance expense	7,381	2,262	9,643
TOTAL OPERATING EXPENSES	141,513	79,227	220,739
GAIN (LOSS) FROM OPERATIONS	(16,450)	(28,315)	(44,765)
NONOPERATING REVENUE:			
Property taxes	13,184	6,837	20,021
Cigarette taxes	1,656	1,294	2,949
Sales taxes	22,397	11,196	33,593
Interest income	1	1	2
Retirement plan contribution	9,798	4,899	14,698
TOTAL NONOPERATING REVENUE	47,036	24,227	71,263
NET INCOME (LOSS)	30,586	(4,087)	26,499

Stroger Hospital
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	91,418	25,743	117,160
Other revenue	378	155	533
Total Revenue	91,796	25,898	117,694
OPERATING EXPENSES:			
Salaries and wages	51,237	24,911	76,147
Employee benefits	13,596	7,785	21,381
Supplies	973	589	1,562
Purchased svs, rental & other	8,717	2,414	11,131
Depreciation	3,966	1,983	5,949
Insurance expense	3,835	1,386	5,222
TOTAL OPERATING EXPENSES	82,326	39,634	121,959
GAIN (LOSS) FROM OPERATIONS	9,470	(13,736)	(4,266)
NONOPERATING REVENUE:			
Property taxes	4,439	2,320	6,759
Cigarette taxes	675	527	1,202
Sales taxes	5,319	2,659	7,977
Retirement plan contribution	5,982	2,991	8,973
TOTAL NONOPERATING REVENUE	16,415	8,497	24,913
NET INCOME (LOSS)	25,886	(5,239)	20,647

ACHN (Clinics)
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	20,949	11,138	32,088
Other revenue	183	84	267
Total Revenue	21,132	11,223	32,355
OPERATING EXPENSES:			
Salaries and wages	6,163	3,402	9,565
Employee benefits	1,872	1,070	2,942
Supplies	4,662	2,543	7,205
Purchased svs, rental & other	473	844	1,317
Depreciation	141	71	212
Insurance expense	553	155	708
TOTAL OPERATING EXPENSES	13,869	8,090	21,959
GAIN (LOSS) FROM OPERATIONS	7,263	3,133	10,396
NONOPERATING REVENUE:			
Property taxes	5,392	2,756	8,148
Cigarette taxes	403	315	717
Sales taxes	5,859	2,929	8,788
Retirement plan contribution	824	412	1,236
TOTAL NONOPERATING REVENUE	12,478	6,411	18,890
NET INCOME (LOSS)	19,741	9,544	29,285

Oak Forest Health Center
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	1,894	2,501	4,395
Other revenue	75	36	110
Total Revenue	1,969	2,537	4,505
OPERATING EXPENSES:			
Salaries and wages	3,883	1,701	5,584
Employee benefits	1,409	569	1,978
Supplies	137	90	227
Purchased svs, rental & other	259	339	598
Depreciation	240	480	720
Insurance expense	1,146	65	1,212
TOTAL OPERATING EXPENSES	7,081	3,417	10,499
GAIN (LOSS) FROM OPERATIONS	(5,113)	(880)	(5,993)
NONOPERATING REVENUE:			
Property taxes	824	436	1,259
Cigarette taxes	161	126	287
Sales taxes	1,576	788	2,363
Interest income	0	0	0
Retirement plan contribution	561	280	841
TOTAL NONOPERATING REVENUE	3,121	1,630	4,751
NET INCOME (LOSS)	(1,992)	749	(1,243)

Provident Hospital
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	10,090	11,215	21,305
Other revenue	41	22	63
Total Revenue	10,131	11,237	21,368
OPERATING EXPENSES:			
Salaries and wages	5,771	2,797	8,567
Employee benefits	1,755	870	2,624
Supplies	50	192	242
Purchased svs, rental & other	750	1,653	2,403
Depreciation	411	205	616
Insurance expense	741	196	937
TOTAL OPERATING EXPENSES	9,561	6,030	15,592
GAIN (LOSS) FROM OPERATIONS	569	5,207	5,776
NONOPERATING REVENUE:			
Property taxes	773	417	1,191
Cigarette taxes	207	162	369
Sales taxes	2,566	1,283	3,849
Retirement plan contribution	694	347	1,041
TOTAL NONOPERATING REVENUE	4,240	2,209	6,449
NET INCOME (LOSS)	4,810	7,416	12,225

Bureau of Health
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue			
Other revenue			
Total Revenue			
OPERATING EXPENSES:			
Salaries and wages	6,952	3,369	10,321
Employee benefits	2,077	1,099	3,176
Supplies	4,867	5,542	10,409
Purchased svs, rental & other	3,134	5,370	8,504
Depreciation	545	272	817
Insurance expense	484	192	676
TOTAL OPERATING EXPENSES	18,059	15,844	33,903
GAIN (LOSS) FROM OPERATIONS	(18,059)	(15,844)	(33,903)
NONOPERATING REVENUE:			
Property taxes	460	236	697
Cigarette taxes	39	31	70
Sales taxes	509	255	764
Retirement plan contribution	800	400	1,201
TOTAL NONOPERATING REVENUE	1,809	921	2,731
NET INCOME (LOSS)	(16,249)	(14,922)	(31,172)

Dept of Public Health
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue	0		0
Other revenue	35	18	53
Total Revenue	36	18	53
OPERATING EXPENSES:			
Salaries and wages	1,257	992	2,249
Employee benefits	239	670	909
Supplies	7	4	11
Purchased svs, rental & other	176	89	265
Depreciation	4	2	7
Insurance expense	150	75	225
TOTAL OPERATING EXPENSES	1,849	1,848	3,697
GAIN (LOSS) FROM OPERATIONS	(1,813)	(1,831)	(3,644)
NONOPERATING REVENUE:			
Property taxes	1,295	673	1,967
Cigarette taxes	171	134	305
Sales taxes	2,155	1,077	3,232
Retirement plan contribution	227	114	341
TOTAL NONOPERATING REVENUE	3,848	1,997	5,845
NET INCOME (LOSS)	2,035	167	2,201

Cermak
Comparative Income Statement of General Funds (Unaudited)
(In Thousands)
Year to Date February 29, 2012

	January 31, 2012	Inc (Dec)	February 29, 2012
REVENUE:			
Net patient service revenue			
Other revenue		0	0
Total Revenue		0	0
OPERATING EXPENSES:			
Salaries and wages	6,377	3,080	9,458
Employee benefits	1,704	905	2,609
Supplies	0	0	0
Depreciation	27	14	41
Insurance expense	471	193	664
TOTAL OPERATING EXPENSES	8,768	4,363	13,131
GAIN (LOSS) FROM OPERATIONS	(8,768)	(4,363)	(13,131)
NONOPERATING REVENUE:			
Sales taxes	4,413	2,206	6,619
Retirement plan contribution	710	355	1,065
TOTAL NONOPERATING REVENUE	5,124	2,561	7,685
NET INCOME (LOSS)	(3,644)	(1,802)	(5,446)

FINANCIAL STATEMENT DISCLOSURE CHECKLIST

Fiscal Year 2012

OBJECTIVE:

The object of this checklist is to help determine if the form and contents of the financial statements are in conformity with the accounting standards applicable to financial statement basis of accounting.

DISCLOSURE PRINCIPLES:

Note: Management can comply with a disclosure principle by making disclosure in body of financial statements or in the notes accompanying the financial statements. In a compilation engagement, management's election to omit substantially all disclosures applies to all disclosure principles in GAAP financial statements.

	Yes, N/A, No?	If no, state reason (immaterial, estimated, etc.)
FINANCIAL STATEMENT REFERENCES:		
1. Do the financial statements reference footnotes (MD&A) or selected information?	Yes	
GENERAL DISCLOSURES:		
A. Estimates:		
1. General disclosure about use of estimates (MD&A)?	Yes	
2. Disclosure of possible changes in estimates?	Yes	
B. Vulnerabilities do to concentrations in following areas disclosed?:		
1. Customers?	Yes	
2. Suppliers?	Yes	
3. Lenders?	Yes	
4. Products?	Yes	
5. Supply of materials, labor or supplies?	Yes	
6. Location of assets in geographic area?	Yes	
C. Related parties (FASB 57):		
1. Known common control and economic dependency disclosure?	Yes	
2. Known transactions with related parties disclosed?	Yes	
OTHER DISCLOSURE AREAS TO BE CONSIDERED:		
1. Method of consolidations?	Yes	
2. Accounting changes including changes in GAAP and in estimates?	Yes	
3. Business combinations?	Yes	
4. Discontinues operations?	Yes	
5. Going concern?	Yes	

COMMENTS:

Completed by _____ **Date** _____

Reviewed by _____ **Date** _____

Cook County Health and Hospitals System

Financial Operations and Statistical Reports (Non GAAP)

For the Month Ended February 29, 2012

Index **Page**

Cash Report as of **2/29/2012**

Cumulative Cash Report as of **2/29/2012**

***** Final Cash Report *****

For the Month February-2012

SHCC	Actual	Budget	Variance
Medicare	$ 5,249,210	$ 4,438,678	$ 810,532
Medicaid	9,439,188	18,694,838	(9,255,650)
Other	1,101,094	2,852,212	(1,751,118)
Physician Billing	149,719	703,600	(553,881)
Medicaid UPL Adjustment	-	1,731,343	(1,731,343)
Medicaid Retroactive Payment	3,146,901	-	3,146,901
Vendor Payments From Revenue			
Pharmacy Billing	-	-	-
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	23,140	-	23,140
Physician Contract Revenues	-	-	-
Totals	**$ 19,109,252**	**$ 28,420,671**	**$ (9,311,419)**

Cumulative Cash Summary Through February-2012

SHCC	Actual	Budget	Variance
Medicare	$ 12,272,642	$ 13,928,266	$ (1,655,624)
Medicaid	26,063,682	48,606,578	(22,542,896)
Other	3,836,356	8,950,042	(5,113,686)
Physician Billing	244,791	1,055,400	(810,609)
Medicaid UPL Adjustment	-	3,582,089	(3,582,089)
Medicaid Retroactive Payment	39,632,769	10,000,000	29,632,769
Vendor Payments From Revenue			
Pharmacy Billing	(287,978)	-	(287,978)
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	35,640	-	35,640
Physician Contract Revenues	25,840	-	25,840
Totals	**$ 81,823,742**	**$ 86,122,375**	**$ (4,298,634)**

PHCC	Actual	Budget	Variance
Medicare	$ 131,107	$ 370,865	$ (239,758)
Medicaid	343,465	1,113,785	(770,320)
Other	70,326	259,125	(188,799)
Physician Billing	23,682	142,900	(119,218)
Medicaid UPL Adjustment	-	-	-
Medicaid Retroactive Payment	-	-	-
Vendor Payments From Revenue			
Pharmacy Billing	-	-	-
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	-	-	-
Physician Contract Revenues	-	-	-
Totals	**$ 568,580**	**$ 1,886,675**	**$ (1,318,095)**

PHCC	Actual	Budget	Variance
Medicare	$ 847,974	$ 1,163,749	$ (315,775)
Medicaid	1,172,123	2,895,841	(1,723,718)
Other	290,977	813,117	(522,140)
Physician Billing	84,078	214,350	(130,272)
Medicaid UPL Adjustment	-	-	-
Medicaid Retroactive Payment	4,396,528	-	4,396,528
Vendor Payments From Revenue	-		
Pharmacy Billing	-	-	-
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	-	-	-
Physician Contract Revenues	-	-	-
Totals	**$ 6,791,681**	**$ 5,087,057**	**$ 1,704,624**

OFHC	Actual	Budget	Variance
Medicare	$ 20,085	$ 59,103	$ (39,018)
Medicaid	523,831	641,073	(117,242)
Other	91,611	132,506	(40,895)
Physician Billing	11,076	53,500	(42,424)
Medicaid UPL Adjustment	-	-	-
Medicaid Retroactive Payment	2,906,137	-	2,906,137
Vendor Payments From Revenue			
Pharmacy Billing	-	-	-
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	-	-	-
Physician Contract Revenues	-	-	-
Totals	**$ 3,552,740**	**$ 886,182**	**$ 2,666,558**

OFHC	Actual	Budget	Variance
Medicare	$ 71,181	$ 185,461	$ (114,280)
Medicaid	999,849	1,666,789	(666,940)
Other	236,521	415,798	(179,277)
Physician Billing	22,954	80,250	(57,296)
Medicaid UPL Adjustment	-	-	-
Medicaid Retroactive Payment	2,906,137	-	2,906,137
Vendor Payments From Revenue	-		
Pharmacy Billing	(3,908)	-	(3,908)
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	-	-	-
Physician Contract Revenues	-	-	-
Totals	**$ 4,232,734**	**$ 2,348,298**	**$ 1,884,436**

SYSTEM	Actual	Budget	Variance
Medicare	$ 5,400,402	$ 4,868,646	$ 531,756
Medicaid	10,306,484	20,449,696	(10,143,212)
Other	1,263,031	3,243,843	(1,980,812)
Physician Billing	184,477	900,000	(715,523)
Medicaid UPL Adjustment	-	1,731,343	(1,731,343)
Medicaid Retroactive Payment	6,053,038	-	6,053,038
Vendor Payments From Revenue			
Pharmacy Billing	-	-	-
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	23,140	-	23,140
Physician Contract Revenues	-	-	-
DSH	12,567,309	11,666,667	900,642
BIPA	-	-	-
Medicaid Malpractice Retro	-	-	-
Totals	**$ 35,797,881**	**$ 42,860,195**	**$ (7,062,314)**

SYSTEM	Actual	Budget	Variance
Medicare	$ 13,191,798	$ 15,277,476	$ (2,085,678)
Medicaid	28,235,654	53,169,208	(24,933,554)
Other	4,363,853	10,178,957	(5,815,104)
Physician Billing	351,824	1,350,000	(998,176)
Medicaid UPL Adjustment	-	3,582,089	(3,582,089)
Medicaid Retroactive Payment	46,935,434	10,000,000	36,935,434
Vendor Payments From Revenue			
Pharmacy Billing	(291,886)	-	(291,886)
Collection Agency	-	-	-
Revenue Enhancement	-	-	-
Physician Billing	-	-	-
Physician Contract Payments	35,640	-	35,640
Physician Contract Revenues	25,840	-	25,840
DSH	37,701,926	35,000,001	2,701,925
BIPA	-	-	-
Medicaid Malpractice Retro	-	-	-
Totals	**$ 130,550,082**	**$ 128,557,731**	**$ 1,992,351**

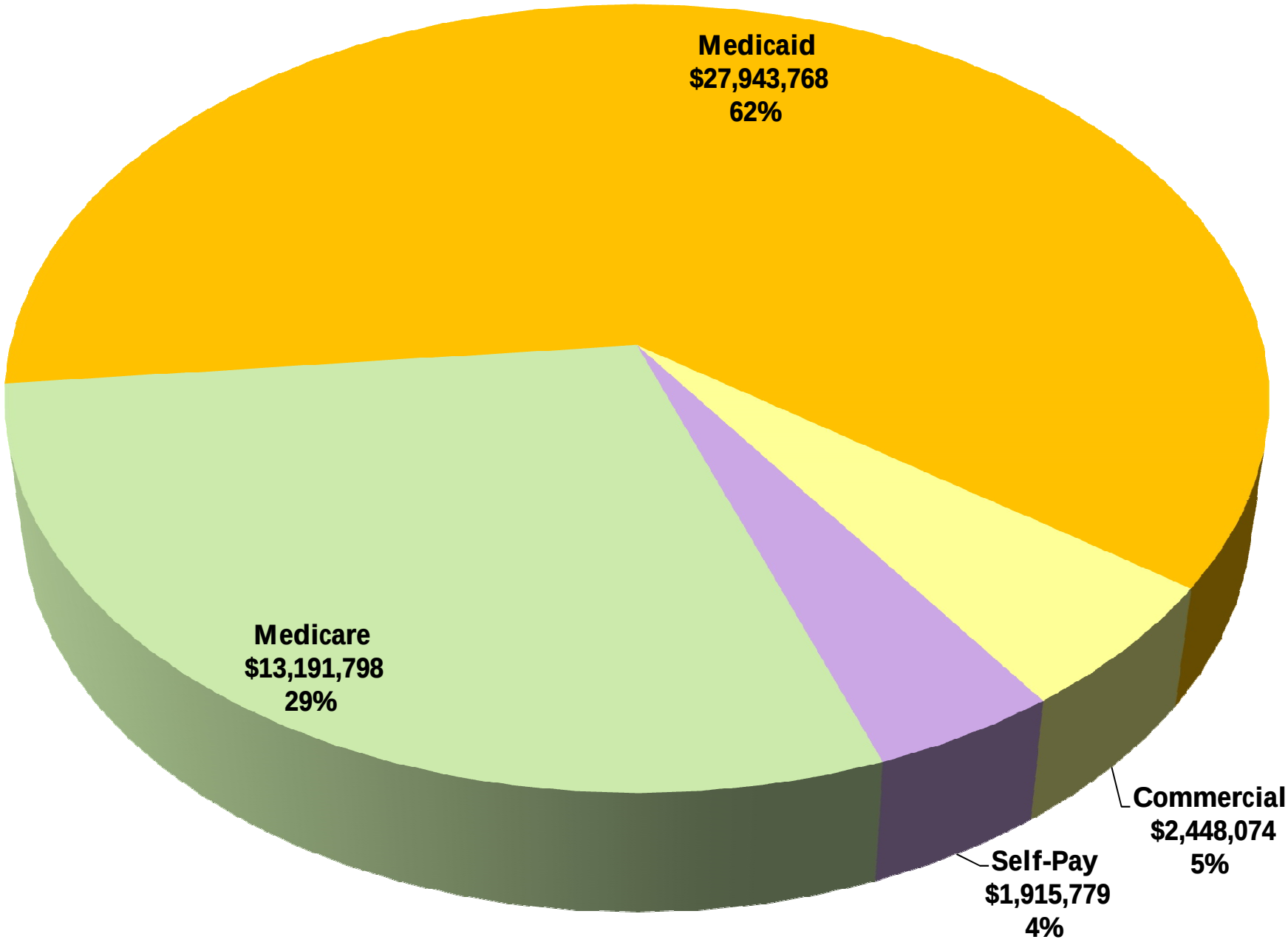
The Medicaid fee-for-service revenue through the IGT covers the period beginning week ended 01/18/2012 - 02/25/2012 .

Vendor Payments From Revenue are payments out of revenue posted by the County Comptroller. Pharmacy Billing and Revenue Enhancement payments are reductions to Medicaid revenue. Collection Agency payments are reductions to Self-Pay (Other) revenue.

The Upper Payment Limit Revision is spread over 11 months, beginning Jan-2012, as it is not known in which month this payment will be received

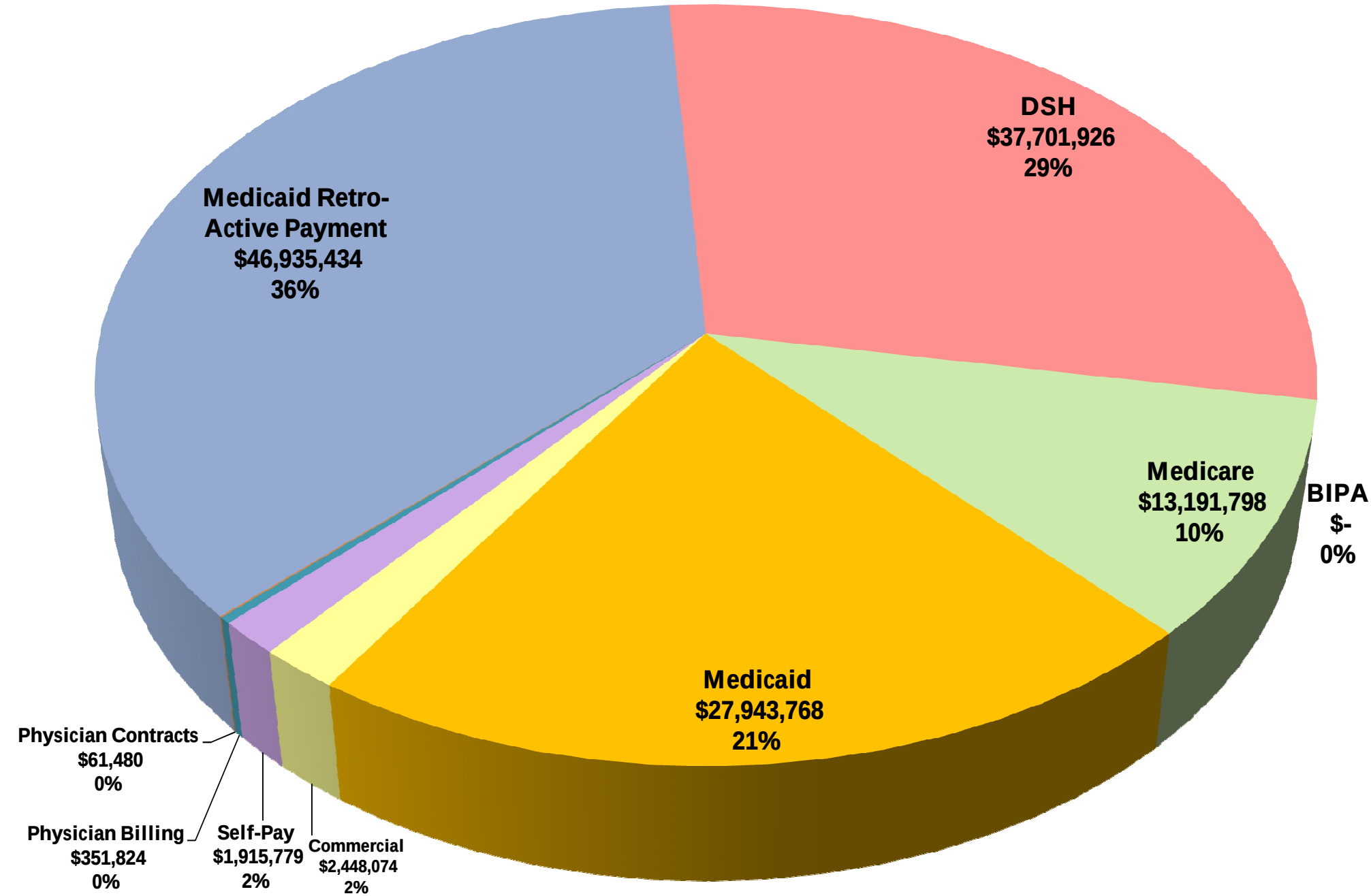
The "Medicaid Retroactive Payment" was budgeted all at SHCC.

CCHHS Cumulative Net Patient Fee Cash Receipts Through February-2012



- The receipts on this graph are net of any payments out of revenue.

CCHHS All Net Cash Receipts Cumulative Total Through February-2012

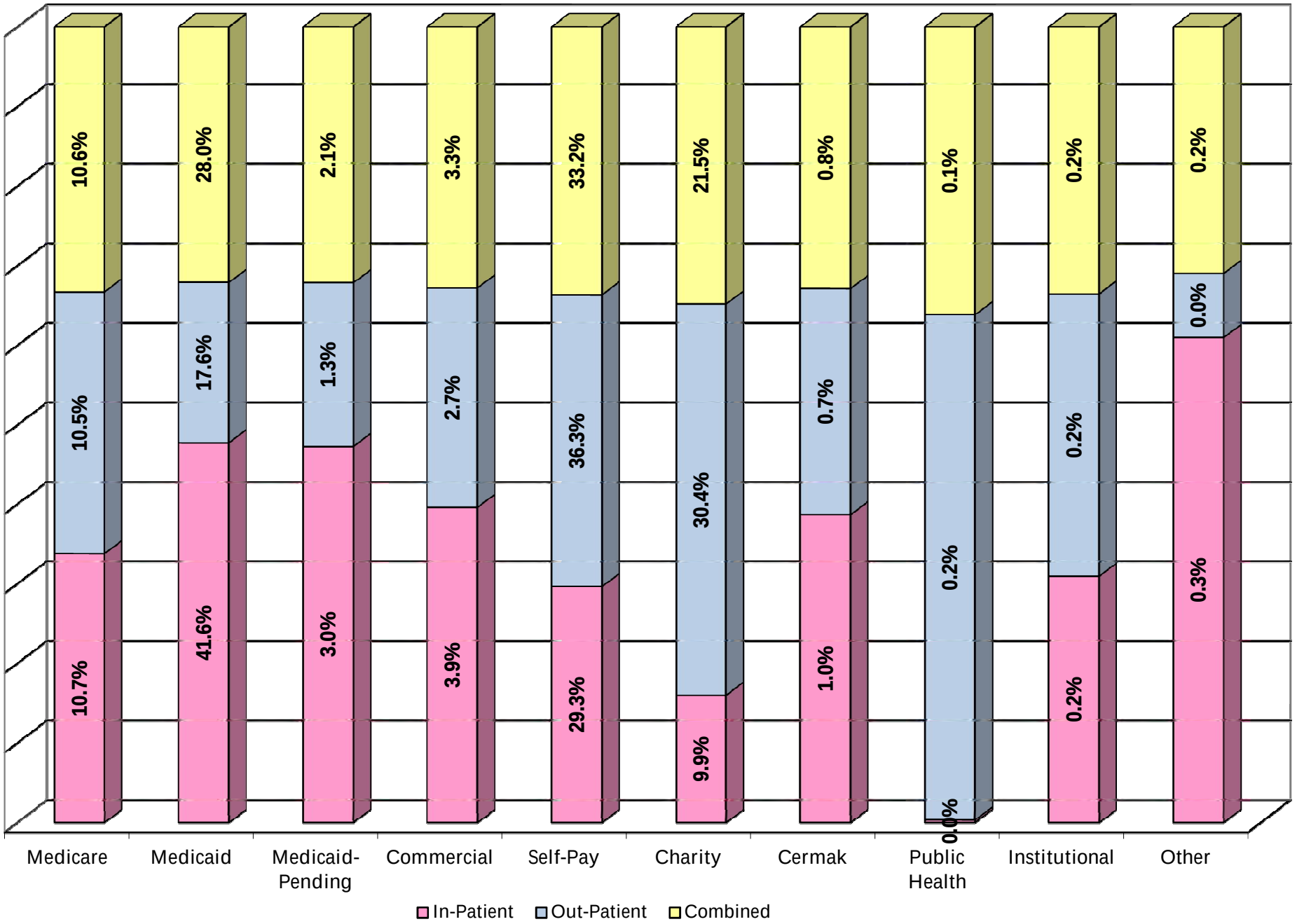


- The receipts on this graph are net of any payments out of revenue.

Cook County Health Facilities
System Expenses per Adjusted Patient Days
Budget and Actual (Non-GAAP Budget Basis)
With Temporary Budget Numbers
As of February 29, 2012

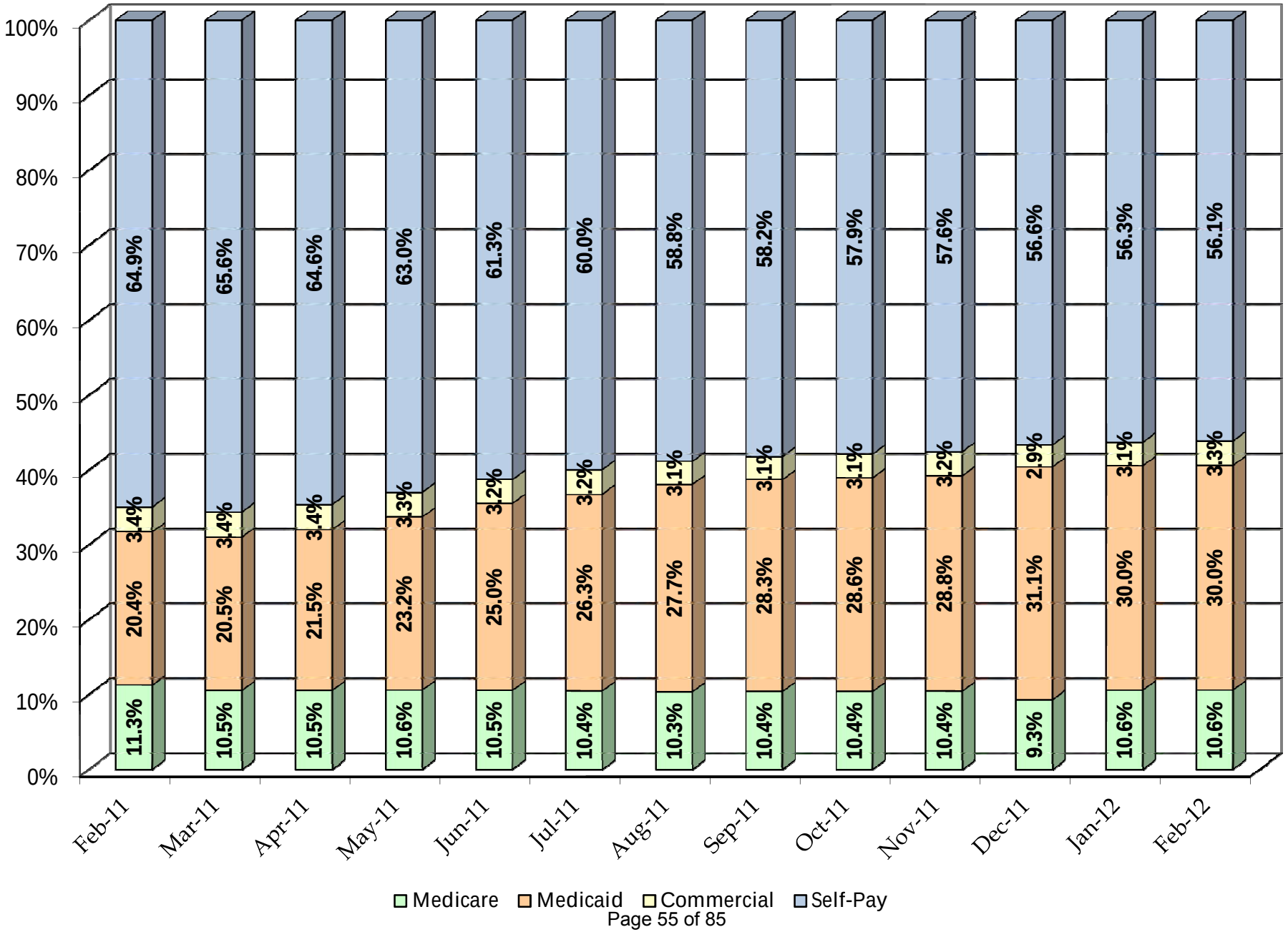
Institution	Actual	Budget	Variance
Stroger	$ 3,278	$ 3,621	9.45%
Provident	$ 3,497	$ 3,777	7.43%

Cumlative CCHHS IP, OP, And Combined Payer Mix Through February-2012 (Based Upon Charges)
Assumes 30% Of Accounts Accepted By Eligibility Vendor Successfully Converted To Medicaid



- The data in this graph is based upon charges.
- Other includes Grants, Risk Management, and Workman's Compensation.

IP And OP Cumulative Combined Payer Mix Comparison (Based Upon Charges)
Cook County Health And Hospitals System
Prior 13 Months Ending February-2012
Assumes 30% of Accounts Accepted By Eligibility Vendor Successfully Converted To Medicaid



CCHHS Utilization Factors
Assumes 30% of Accounts Accepted by Eligibility Vendor Successfully Converted to Medicaid
February-2012

Admissions

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	209	203	6	18	54	(36)	-	-	-	227	257	(30)
Medicaid	443	658	(215)	28	65	(37)	-	-	-	471	723	(252)
Medicaid-Pending	126	-	126	5	-	5	-	-	-	131	-	131
Commercial	60	53	7	5	4	1	-	-	-	65	57	8
Self-Pay	888	873	15	60	92	(32)	-	-	-	948	965	(17)
Charity	96	-	96	29	-	29	-	-	-	125	-	125
Cermak	23	-	23	-	-	-	-	-	-	23	-	23
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	3	-	3	-	-	-	-	-	-	3	-	3
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	3	-	3	-	-	-	-	-	-	3	-	3
Total Admissions	**1,851**	**1,787**	**64**	**145**	**215**	**(70)**	**-**	**-**	**-**	**1,996**	**2,002**	**(6)**

Patient Days

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	1,061	1,062	(1)	89	136	(47)	-	-	-	1,150	1,198	(48)
Medicaid	2,712	3,600	(888)	97	210	(113)	-	-	-	2,809	3,810	(1,001)
Medicaid-Pending	709	-	709	24	-	24	-	-	-	733	-	733
Commercial	437	282	155	21	22	(1)	-	-	-	458	304	154
Self-Pay	3,723	4,077	(354)	197	284	(87)	-	-	-	3,920	4,361	(441)
Charity	368	-	368	114	-	114	-	-	-	482	-	482
Cermak	78	-	78	-	-	-	-	-	-	78	-	78
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	39	-	39	-	-	-	-	-	-	39	-	39
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	65	-	65	-	-	-	-	-	-	65	-	65
Total Patient Days	**9,192**	**9,021**	**171**	**542**	**652**	**(110)**	**-**	**-**	**-**	**9,734**	**9,673**	**61**

Adjusted Patient Days

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	2,310	2,075	235	343	466	(123)	-	-	-	2,653	2,541	112
Medicaid	5,904	7,035	(1,131)	373	719	(346)	-	-	-	6,277	7,754	(1,477)
Medicaid-Pending	1,543	-	1,543	93	-	93	-	-	-	1,636	-	1,636
Commercial	951	551	400	81	75	6	-	-	-	1,032	626	406
Self-Pay	8,104	7,967	137	760	972	(212)	-	-	-	8,864	8,939	(75)
Charity	801	-	801	440	-	440	-	-	-	1,241	-	1,241
Cermak	170	-	170	-	-	-	-	-	-	170	-	170
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	85	-	85	-	-	-	-	-	-	85	-	85
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	141	-	141	-	-	-	-	-	-	141	-	141
Total Adjusted Patient Days	**20,009**	**17,628**	**2,381**	**2,090**	**2,232**	**(142)**	**-**	**-**	**-**	**22,099**	**19,860**	**2,239**

Average Length of Stay

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center - Acute			Oak Forest Specialty Health Center - Rehabilitation		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	4.6	5.0	(0.4)	4.9	4.0	0.9	-	-	-	-	-	-
Medicaid	6.4	5.0	1.4	3.6	4.0	(0.4)	-	-	-	-	-	-
Medicaid-Pending	5.0	5.0	0.0	4.9	4.0	0.9	-	-	-	-	-	-
Commercial	6.2	5.0	1.2	3.6	4.0	(0.4)	-	-	-	-	-	-
Self-Pay	4.2	5.0	(0.8)	3.4	4.0	(0.6)	-	-	-	-	-	-
Charity	4.0	5.0	(1.0)	3.9	4.0	(0.1)	-	-	-	-	-	-
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Cermak	3.2	5.0	(1.8)	-	-	-	-	-	-	-	-	-
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	10.5	5.0	5.5	-	-	-	-	-	-	-	-	-
Workmens' Compensation	9.3	5.0	4.3	-	-	-	-	-	-	-	-	-
Overall Average LOS	4.9	**5.0**	**(0.1)**	3.8	4.0	(0.2)	**-**	**-**	**-**	**-**	**-**	**-**

-The primary insurance has been used to determine "Payer Type".
-"Medicaid-Pending" assumes 30% of the Self-Pay accounts accepted by the eligibility vendor will be successfully converted to Medicaid accounts.

CCHHS Utilization Factors
Assumes 30% of Accounts Accepted by Eligibility Vendor Successfully Converted to Medicaid
Cumulative For Fiscal Year 2011 Through February-2012

Admissions

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	658	695	(37)	61	191	(130)	-	-	-	719	886	(167)
Medicaid	1,327	2,138	(811)	63	251	(188)	-	-	-	1,390	2,389	(999)
Medicaid-Pending	512	-	512	15	-	15	-	-	-	527	-	527
Commercial	178	148	30	7	24	(17)	-	-	-	185	172	13
Self-Pay	2,888	2,822	66	211	337	(126)	-	-	-	3,099	3,159	(60)
Charity	177	-	177	63	-	63	-	-	-	240	-	240
Cermak	85	-	85	-	-	-	-	-	-	85	-	85
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	8	-	8	-	-	-	-	-	-	8	-	8
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	6	-	6	-	-	-	-	-	-	6	-	6
Total Admissions	**5,839**	**5,803**	**36**	**420**	**803**	**(383)**	**-**	**-**	**-**	**6,259**	**6,606**	**(347)**

Patient Days

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	3,093	3,339	(246)	262	426	(164)	-	-	-	3,355	3,765	(410)
Medicaid	7,525	11,046	(3,521)	201	660	(459)	-	-	-	7,726	11,706	(3,980)
Medicaid-Pending	2,848	-	2,848	73	-	73	-	-	-	2,921	-	2,921
Commercial	1,055	1,007	48	29	70	(41)	-	-	-	1,084	1,077	7
Self-Pay	12,816	13,124	(308)	754	892	(138)	-	-	-	13,570	14,016	(446)
Charity	690	-	690	235	-	235	-	-	-	925	-	925
Cermak	365	-	365	-	-	-	-	-	-	365	-	365
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	54	-	54	-	-	-	-	-	-	54	-	54
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	73	-	73	-	-	-	-	-	-	73	-	73
Total Patient Days	**28,519**	**28,516**	**3**	**1,554**	**2,048**	**(494)**	**-**	**-**	**-**	**30,073**	**30,564**	**(491)**

Adjusted Patient Days

	Stroger Hospital			Provident Hospital			Oak Forest Specialty Health Center			System Total		
Payer Type	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medicare	6,609	6,525	84	1,018	1,458	(440)	-	-	-	7,627	7,983	(356)
Medicaid	16,083	21,585	(5,502)	779	2,259	(1,480)	-	-	-	16,862	23,844	(6,982)
Medicaid-Pending	6,068	-	6,068	284	-	284	-	-	-	6,352	-	6,352
Commercial	2,259	1,968	291	112	239	(127)	-	-	-	2,371	2,207	164
Self-Pay	27,338	25,646	1,692	2,933	3,054	(121)	-	-	-	30,271	28,700	1,571
Charity	1,482	-	1,482	913	-	913	-	-	-	2,395	-	2,395
Cermak	777	-	777	-	-	-	-	-	-	777	-	777
Grants	-	-	-	-	-	-	-	-	-	-	-	-
Institutional	116	-	116	-	-	-	-	-	-	116	-	116
Public Health	-	-	-	-	-	-	-	-	-	-	-	-
Workmens' Compensation	158	-	158	-	-	-	-	-	-	158	-	158
Total Adjusted Patient Days	**60,890**	**55,724**	**5,166**	**6,039**	**7,010**	**(971)**	**-**	**-**	**-**	**66,929**	**62,734**	**4,195**

-The primary insurance has been used to determine "Payer Type".
-"Medicaid-Pending" assumes 30% of the Self-Pay accounts accepted by the eligibility vendor will be successfully converted to Medicaid accounts.

CCHHS Utilization Factors

Assumes 30% of Accounts Accepted by Eligibility Vendor Successfully Converted to Medicaid

Emergency Room And Immediate Care Visits For February-2012

Stroger Hospital

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Total Visits
Medicare	475	166	74	715
Medicaid	2,302	246	55	2,603
Medicaid-Pending	176	86	12	274
Commercial	248	35	14	297
Self-Pay	4,641	647	813	6,101
Charity	974	60	64	1,098
Cermak	55	21	-	76
Grants & Research	-	-	-	-
Public Health	19	-	-	19
Institutional	41	3	3	47
Workmens' Compensation	4	2	1	7
Totals	**8,935**	**1,266**	**1,036**	**11,237**
			Budget	8,694
			Variance	**2,543**

Provident Hospital

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Total Visits
Medicare	129	17	13	159
Medicaid	419	23	12	454
Medicaid-Pending	20	5	1	26
Commercial	51	4	7	62
Self-Pay	1,582	55	152	1,789
Charity	337	23	3	363
Cermak	2	-	-	2
Grants & Research	-	-	-	-
Public Health	1	-	-	1
Institutional	-	-	-	-
Workmens' Compensation	-	-	-	-
Totals	**2,541**	**127**	**188**	**2,856**
			Budget	2,915
			Variance	**(59)**

Oak Forest Specialty Health Center

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Immediate Care Visits
Medicare	-	-	-	67
Medicaid	-	-	-	88
Medicaid-Pending	-	-	-	3
Commercial	-	-	-	20
Self-Pay	-	-	-	954
Charity	-	-	-	450
Cermak	-	-	-	-
Grants & Research	-	-	-	-
Public Health	-	-	-	-
Institutional	-	-	-	-
Workmens' Compensation	-	-	-	-
Totals	**-**	**-**	**-**	**1,582**
			Budget	2,536
			Variance	**(954)**

ER and Immediate Care Total

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Immediate Care Visits	Total Visits ER and Immediate Care
Medicare	604	183	87	67	941
Medicaid	2,721	269	67	88	3,145
Medicaid-Pending	196	91	13	3	303
Commercial	299	39	21	20	379
Self-Pay	6,223	702	965	954	8,844
Charity	1,311	83	67	450	1,911
Cermak	57	21	-	-	78
Grants & Research	-	-	-	-	-
Public Health	20	-	-	-	20
Institutional	41	3	3	-	47
Workmens' Compensation	4	2	1	-	7
Totals	**11,476**	**1,393**	**1,224**	**1,582**	**15,675**
				ER and Immediate Care Budget	14,145
				Variance	**1,530**

Percent Of Admissions From Emergency Room For Month Of February-2012

	SHCC	PHCC	OFHC	CCHHS
ER Admissions	1,266	127	-	1,393
Total Admisisons	1,851	145	-	1,996
% of ER Admissions	68%	88%	0%	70%

Notes:

- ER Elopes are patients who leave without being seen by a physician.
- "Medicaid-Pending" assumes 30% of the Self-Pay accounts accepted by the eligibility vendor will be successfully converted to Medicaid accounts.

CCHHS Utilization Factors
Assumes 30% of Accounts Accepted by Eligibility Vendor Successfully Converted to Medicaid
Cumulative Emergency Room And Immediate Care Visits Through February-2012

Stroger Hospital

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Total Visits
Medicare	1,312	520	239	2,071
Medicaid	4,758	777	396	5,931
Medicaid-Pending	545	352	26	923
Commercial	746	98	48	892
Self-Pay	16,474	2,066	2,662	21,202
Charity	2,741	113	378	3,232
Cermak	167	76	5	248
Grants & Research	1	-	1	2
Public Health	56	-	-	56
Institutional	115	8	6	129
Workmens' Compensation	12	5	4	21
Totals	**26,927**	**4,015**	**3,765**	**34,707**
			Budget	28,514
			Variance	**6,193**

Provident Hospital

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Total Visits
Medicare	444	58	28	530
Medicaid	1,239	56	84	1,379
Medicaid-Pending	50	15	2	67
Commercial	185	6	15	206
Self-Pay	4,971	197	336	5,504
Charity	920	48	44	1,012
Cermak	2	-	-	2
Grants & Research	-	-	-	-
Public Health	4	-	-	4
Institutional	1	-	-	1
Workmens' Compensation	3	-	-	3
Totals	**7,819**	**380**	**509**	**8,708**
			Budget	9,145
			Variance	**(437)**

Oak Forest Specialty Health Center

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Immediate Care Visits
Medicare	-	-	-	219
Medicaid	-	-	-	280
Medicaid-Pending	-	-	-	8
Commercial	-	-	-	69
Self-Pay	-	-	-	3,485
Charity	-	-	-	1,347
Cermak	-	-	-	-
Grants & Research	-	-	-	-
Public Health	-	-	-	1
Institutional	-	-	-	5
Workmens' Compensation	-	-	-	-
Totals	**-**	**-**	**-**	**5,414**
			Budget	7,958
			Variance	**(2,544)**

ER and Immediate Care Total

Payer Type	ER Patients Treated And Released	Admissions From ER	ER Elopes	Immediate Care Visits	Total Visits ER and Immediate Care
Medicare	1,756	578	267	219	2,820
Medicaid	5,997	833	480	280	7,590
Medicaid-Pending	595	367	28	8	998
Commercial	931	104	63	69	1,167
Self-Pay	21,445	2,263	2,998	3,485	30,191
Charity	3,661	161	422	1,347	5,591
Cermak	169	76	5	-	250
Grants & Research	1	-	1	-	2
Public Health	60	-	-	1	61
Institutional	116	8	6	5	135
Workmens' Compensation	15	5	4	-	24
Totals	**34,746**	**4,395**	**4,274**	**5,414**	**48,829**
			ER and Immediate Care Budget		45,617
			Variance		**3,212**

Percent Of Admissions From Emergency Room Cumulatively Through February-2012

	SHCC	PHCC	OFHC	CCHHS
ER Admissions	4,015	380	-	4,395
Total Admisisons	5,839	420	-	6,259
% of ER Admissions	69%	90%	0%	70%

Notes:
- ER Elopes are patients who leave without being seen by a physician.
- "Medicaid-Pending" assumes 30% of the Self-Pay accounts accepted by the eligibility vendor will be successfully converted to Medicaid accounts.

CCHHS Utilization Factors
ACHN Clinic Visits

ACHN Clinic Visits - February-2012

	Actual	Budget	Variance
FANTUS / STROGER SCC CAMPUS	31,224	31,436	(212)
WEST CLUSTER	6,306	6,119	187
SOUTH CLUSTER	5,997	5,481	516
SOUTH SUBURBAN CLUSTER	5,312	4,930	382
Total ACHN Visits	**48,839**	**47,966**	**873**

Cumulative ACHN Clinic Visits Through February-2012

	Actual	Budget	Variance
FANTUS / STROGER SCC CAMPUS	94,790	98,644	(3,854)
WEST CLUSTER	18,471	19,201	(730)
SOUTH CLUSTER	16,899	17,199	(300)
SOUTH SUBURBAN CLUSTER	15,869	15,470	399
Total ACHN Visits	**146,029**	**150,514**	**(4,485)**

Cook County Health and Hospitals System
Top Ten DRG's - February-2012

John H. Stroger, Jr. Hospital of Cook County

Rank	DRG and Description	Total Patients	Total Days	Avg LOS	Case Mix	MEDICARE Geometric Avg LOS
1	313 CHEST PAIN	55	97	1.8	0.5434	1.7
2	392 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O M	53	148	2.8	0.7241	2.7
3	775 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	40	101	2.5	0.5283	2.1
4	812 RED BLOOD CELL DISORDERS W/O MCC	36	91	2.5	0.7920	2.7
5	690 KIDNEY & URINARY TRACT INFECTIONS W/O MCC	30	101	3.4	0.7870	3.3
6	794 NEONATE W OTHER SIGNIFICANT PROBLEMS	27	98	3.6	1.2227	3.4
7	292 HEART FAILURE & SHOCK W CC	24	96	4.0	1.0214	3.9
8	847 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOS	24	108	4.5	1.0146	2.8
9	192 CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	24	51	2.1	0.7081	3.0
10	203 BRONCHITIS & ASTHMA W/O CC/MCC	24	57	2.4	0.6133	2.6

Provident Hospital of Cook County

Rank	DRG and Description	Total Patients	Total Days	Avg LOS	Case Mix	MEDICARE Geometric Avg LOS
1	313 CHEST PAIN	27	80	3.0	0.5434	1.7
2	293 HEART FAILURE & SHOCK W/O CC/MCC	13	44	3.4	0.6756	2.7
3	292 HEART FAILURE & SHOCK W CC	8	66	8.3	1.0214	3.9
4	743 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	8	27	3.4	0.9306	1.8
5	194 SIMPLE PNEUMONIA & PLEURISY W CC	6	30	5.0	1.0026	4.0
6	192 CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	6	24	4.0	0.7081	3.0
7	312 SYNCOPE & COLLAPSE	4	8	2.0	0.7139	2.3
8	203 BRONCHITIS & ASTHMA W/O CC/MCC	4	15	3.8	0.6133	2.6
9	742 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	3	6	2.0	1.4262	3.0
10	202 BRONCHITIS & ASTHMA W CC/MCC	3	15	5.0	0.8519	3.3

ATTACHMENT #3

Cook County Health & Hospitals System

A. Update on Revenue Cycle Initiatives

B. CareLink Status Report

C. Financial Dashboard

Report of the Interim Chief Financial Officer

CCHHS Finance Committee Meeting

April 20, 2012

Update on Revenue Cycle Initiatives

- Collections in March are trending upward for all payers. This trend is the result of the reduction in unbilled accounts and the resolution of some of the edit issues associated with the installation of the Emdeon system.

- The CCHHS Revenue Integrity Group is working on mapping the orders in Cerner to the Siemens billing system. It was discovered that there were over three thousand orders that were not mapped in the past.

- The new Centralized Billing Office at Oak Forest has reconciled the vouchers associated with the large number of Medicaid provider numbers to the posted payments to the Siemens system. This process uncovered 70 vouchers that had not been posted. This is an example of the benefits of creating the CBO so that there is uniformity in operations and resources can be shared.

Update on Revenue Cycle Initiatives

- Work has begun on closing down the three legacy billing systems. The goal is to eliminate the use of the systems by June 2012. The elimination of the three systems will save on-going fees paid to Siemens.

- Print images of bills from the legacy systems will be maintained in a server so that any potential re-billing of claims from those systems will be relatively easy.

- The use of the electronic posting service is to be extended to additional payers so that CCHHS staff can be re-assigned to collection and follow-up activities. Electronic posting is currently operational for Medicaid, Medicare, and Blue Cross.

Revenue Cycle Initiatives

- The level of pending Medicaid applications at the end of March 2012 has been reduced by 37% since September 2011.
- The pending federal disability applications at the end of March 2012 is down by 41% from September 2011.
- The joint effort of CEA and DHS has reduced the applications that are being reviewed outside the DHS central office unit in the area offices by 53.7% at the end of March 2012 as compared to November 2011.
- The processing of Spend Down (2432) Applications has improved greatly by the end of March 2012.

Update on Revenue Cycle Initiatives

Cash Collections vs Budget

	December	January	February	March	March YTD	Budget YTD	(worse)
Medicare	$ 3,939,625	$ 3,851,771	$ 5,400,402	$ 5,427,435	$ 18,619,233	$ 20,481,891	$ (1,862,658)
Medicaid	$ 9,400,191	$ 8,526,520	$ 10,306,484	$ 11,124,471	$ 39,360,125	$ 69,528,964	$ (30,168,839)
Other	$ 1,833,470	$ 1,267,402	$ 1,263,031	$ 1,986,810	$ 6,350,663	$ 13,646,514	$ (7,295,851)
Physician Billing	$ 77,171	$ 90,176	$ 184,477	$ 222,180	$ 574,004	$ 2,700,000	$ (2,125,996)
Medicaid UPL Adj.	$ -	$ -	$ -		$ -	$ 5,432,835	$ (5,432,835)
Medicaid Retro Rate Adj.		$ 40,884,855	$ 6,053,038		$ 46,932,975	$ 10,000,000	$ 36,932,975
Physician Contract Payments	$ 12,500		$ 23,140		$ 35,640		$ 35,640
Physician Contract Revenues	$ 25,840		$ -	$ 181,198	$ 207,038		$ 207,038
DSH	$ 12,567,308	$ 12,567,309	$ 12,567,309	$ 12,567,309	$ 50,269,235	$ 46,666,668	$ 3,602,567
BIPA	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Payments from revenue					$ (323,331)		$ (323,331)
Total	$ 27,856,105	$ 67,188,033	$ 35,797,881	$ 31,509,403	$ 162,025,582	$ 168,456,872	**$ (6,431,290)**

CareLink Status Report

- Over 19,000 patients have been approved for CareLink.

CareLink Statistics - Fiscal Year To Date

Approved CareLink Applications		
Discount Level		
100%	18726	98.1%
50%	302	1.6%
25%	61	0.3%
Total CareLink Approved Applications	**19089**	**100.0%**
Denied CareLink Applications		
Medicaid eligible or active Medicaid	742	86.2%
Residency	74	8.6%
Income	23	2.7%
Access to Insurance	22	2.6%
Total Denied CareLink Applications	**861**	**100.0%**
Total Applications and the Portion of Applications Approved	**19950**	**95.7%**

CareLink Status Report

- Almost 75 million dollars of CareLink discounts have been applied to patient self pay bills for this fiscal year.

CareLink Discounts Applied to Billed Accounts		Inpatient		Outpatient		Total
December	$	3,090,281	$	15,885,191	$	18,975,472
January	$	2,140,721	$	11,919,269	$	14,059,991
February	$	3,017,849	$	15,085,802	$	18,103,651
March	$	3,427,846	$	19,958,199	$	23,386,045
YTD Discounts Applied to Billed Accounts	**$**	**11,676,697**	**$**	**62,848,462**	**$**	**74,525,159**

CareLink Status Report

- **CareLink implementation issues** - There is a need to increase the number of CHHS employees to staff Central Registration, Central Scheduling, CareLink, and Cashiering. Existing staffing resources are being re-assigned from other areas to these projects along with an effort to post and fill open positions. These staffing issues may impact the ability of CCHHS to fully implement all of these programs.

- **Pharmacy Software System Changes** – The current Pharmacy system has limits on its ability to bill patients that are unable to pay the co-pay amounts at the time of pick-up of prescriptions. A new system is being installed that will provide for appropriate patient and insurance billing. The new system will also help determine the correct co-pay amounts for governmental programs so that CCHHS can be in compliance with program rules.

Financial Dashboard

- The latest Dashboard includes financial and utilization information. Labor information will be added next month for all of the fiscal year.

- The Dashboard can be distributed through e-mail or as part of CCHHS's monthly reporting to the Board of Directors.

- Additional statistics can be added if the Board would like to see additional items.

Financial Dashboard

CCHHS Dasboard Information - 2012

Revenue & Accounts Receivable

	December	January	February
Self Pay Percentage - Gross Charges	**57%**	**56%**	**55%**
Unbilled Inpatient Accounts over 5 days	$ 10,205,785	$ 5,933,308	$ 3,268,451
Unbilled Outpatient Accounts	$ 22,534,776	$ 23,355,905	$ 21,675,531
Inpatient Accounts Receivable - Billed	$ 210,443,699	$ 179,257,581	$ 246,676,173
Outpatient Accounts Receivable - Billed	$ 172,534,898	$ 179,257,581	$ 190,738,561
Days in Revenue Outstanding	**167**	**176**	**177**
CEA Medicaid Application Inventory	**9966**	**9163**	**8304**

Volume

Patient Days - Stroger	9791	9536	9561
Patient Days - Provident	502	510	514
Admissions - Stroger	2026	1962	1982
Admissions - Provident	143	132	134
Births - Stroger	46	57	53
Average Length of Stay - Stroger	4.9	4.9	4.9
Average Length of Stay - Provident	3.9	3.9	3.9
ER Visits - Stroger	11716	11754	9023
ER - Visits - Provident	2299	2979	2739
Immediate Care Visits - Oak Forest	1868	1964	1966
Clinic Visits	47586	49604	48839

Labor

Productive Dollars	TBD	TBD	TBD
Productive FTE's			
Non-Productive Dollars			
Non Productive FTE's			

ATTACHMENT #4

FOR IMMEDIATE RELEASE
April 19, 2012

Governor Quinn Announces Plan to Stabilize Illinois' Medicaid System
Proposal Saves Medicaid System for Millions

SPRINGFIELD – April 19, 2012. Governor Pat Quinn today announced a plan to stabilize Illinois' Medicaid system and prevent collapse of the program, one of his top priorities this session. The Governor's plan creates $2.7 billion in Medicaid savings – which includes more than $2 billion in Medicaid reductions and federal matching funds from additional revenues on tobacco products. Today's proposal follows weeks of productive talks led by the governor's office with a working group comprised of members from all four legislative caucuses, as well as meetings with numerous provider groups.

"We must act quickly to save the entire Medicaid system from collapse, and protect providers and the millions of Illinois residents that depend upon Medicaid for their healthcare," Governor Quinn said. "This proposal will fundamentally restructure our Medicaid system, alleviate the pressures on the rest of our budget, and ensure the program is sustainable for years to come."

Medicaid provides healthcare to 2.7 million people in Illinois and coverage for half of all births. In his February budget address, the Governor highlighted the urgent need for a $2.7 billion reduction in the Medicaid program to prevent systemic collapse. At the end of the current fiscal year (FY 2012), Illinois will have $1.9 billion in unpaid Medicaid bills. The Civic Federation projects $21 billion in unpaid Medicaid bills by 2017 if Illinois' Medicaid system is not fundamentally and immediately restructured.

The Governor convened a working group – comprised of members from each of the four legislative caucuses – to explore all options and develop a framework to save our Medicaid system. The working group met with and incorporated suggestions from many provider groups, including: hospitals, podiatrists, durable and disposable medical equipment companies, long-term care providers, dentists, pharmacists, and hospice providers.

Governor Quinn's proposal reduces Illinois' Medicaid liability by $2.7 billion, with three-quarters of the plan comprised of cuts, reductions and efficiencies, one-eighth in state revenue, and one-eighth in federal matching funds:

- Cuts, reductions and efficiencies to 58 separate items totaling $1.35 billion (50 percent)
- Rate reduction to providers totaling $675 million – (25 percent)
- Additional revenue through a $1 per pack increase in the cigarette tax totaling $337.5 million (12.5 percent)
- 100 percent federal match funding from the increased cigarette tax totaling $337.5 million (12.5 percent)

"The status quo is not an option, and I want to thank the members of the working group, who have worked diligently with us to find real solutions to this problem, "Julie Hamos, Department of Healthcare and Family Services director, said. "What we are presenting today is a balanced approach that targets fraud and abuse, continues our move to coordinated care for Medicaid clients, and takes advantage of federal matching funds to make every dollar go further."

The cuts, reductions and efficiencies across 58 separate items in the Governor's proposal include:

- Program integrity to prevent client and provider fraud
- Elimination or reduced coverage of certain optional populations and services
- Controls on use of Medicaid services to prevent over-use or waste
- Adjustments to rates that are outdated or do not reflect budget realities
- Expanded cost-sharing by clients
- Redesigned healthcare delivery system through Coordinated Care
- Complete implementation of all reforms in 2011 Medicaid reform law

To access more funds from the federal government, the Governor's plan to limit Medicaid liability includes a tobacco revenue increase. By including a tobacco revenue increase, which amounts to just one-eighth ($337.5 million per year) of the $2.7B savings we must find in the Medicaid program, the state will be eligible for an additional 100 percent in federal matching funds ($337.5 million per year).

In addition to the direct revenue, raising the cost of cigarettes by a dollar will improve the health of the people of Illinois, reducing tobacco-related Medicaid and health care costs over the long-term. According to the American Cancer Society, tobacco use cost Illinois $1.5 billion in Medicaid spending last year. Increasing the cigarette tax by a dollar a pack will prevent more than 70,000 children from becoming addicted adult smokers, decrease youth smoking by 11 percent and save more than 38,000 Illinois residents from premature, smoking-caused death.

"The American Cancer Society is pleased to see the Governor combining smart fiscal and public health policy with this proposal," said Katherine L. Griem, M.D., President of the American Cancer Society, Illinois Division. "Smoking remains the leading cause of cancer and this proposal will not only reduce the burden on the state's Medicaid program for years to come, but more importantly, it will save lives and improve the health of people across Illinois, particularly in curtailing youth smoking."

Related Materials

- Spending Reductions (PDF, 341 KB)
- Stabilization Fact Sheet (PDF, 483 KB)

Media Availability Archive: Video | Audio Only

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Dollars in Thousands

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
1	Eligibility	Family Care adults	Reduce eligibility to 133% FPL; eliminate coverage for grandfathered adults 185%-400%	133% will be the national standard for Medicaid under the Affordable Care Act, effective 1/1/14. Medicaid is not enrolling parents and other caretakers with income 185%-400% FPL; current group includes only persons enrolled at the end of June 2009, and federal match is not available for the costs of covering this population.	$49,884.7	Impacts approximately 26,400 clients. Average annual cost per client: $1,890.
2	Eligibility	General Assistance adults	Eliminate coverage for all clients	State-only program. Could move clients to Cook County 1115 waiver, if approved by GA and federal CMS.	$16,681.3	Impacts approximately 9,160 clients. Average annual cost per client: $1,821.
3	Eligibility	IL Cares Rx	Terminate program	State-only program. Other states dropped coverage when Medicare D became available. National healthcare reform law is providing more assistance for drug costs in "donut hole". Federal program, "Extra Help/Low Income Subsidy", provides federal assistance for low-income seniors.	$72,154.0	Impacts approximately 180,000 clients.
4	Eligibility	Enhanced eligibility verification	Conduct full review of ongoing eligibility in Medicaid program	Important to ensure that clients do not remain on the Medicaid rolls when they are no longer eligible.	$120,000.0	This effort includes conducting required annual redeterminations, and cancelling cases for clients with out-of-state address, those with income over the Medicaid income standard, those who are deceased, or children aging out of the AllKids Program at age 19. It will require human resource and systems investments at HFS.
5	Optional Service	REACH Program	Terminate contract effective 06/30/12	Program is at risk of losing federal match	$3,000.0	Cost to Dept. on Aging as clients shift to Community Care program. Impacts approximately 240 participants.
6	Optional Service	Group psychotherapy for NH residents (and related transportation)	Eliminate services	Despite some controls, there continues to be overuse of this service. If needed, psychotherapist should come to nursing home.	$14,256.1	10,420 distinct recipients in FY 2011.
7	Optional Service	Pediatric palliative care	Repeal law before it is implemented	State cannot afford to begin a new optional service. No clients are affected.	$4,500.0	Colorado study - spending almost $15M. Estimated to impact approximately 1,000 clients.
8	Optional Service	Adult eyeglasses	New policy: one pair every 2 years	Limit to 1 pair every 2 years would be in line with other payors.	$509.9	First year savings figure. Second year savings figure of $9,819.5. Statute requires coverage for persons participating in DHS educational or work programs. For the remaining population, the service is optional.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
9	Optional Service	Adult chiropractic	Eliminate	For adults, currently there is no review of diagnosis or limits on number of sessions. HFS will also implement reviews to ensure appropriate services to children.	$884.5	Impacts approximately 9,600 clients.
10	Optional Service	Adult speech, hearing and language therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$411.0	Impacts approximately 500 clients.
11	Optional Service	Adult occupational therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$596.7	Encourages utilization control and covers therapies to keep clients in their homes.
12	Optional Service	Adult physical therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$2,544.9	Encourages utilization control and covers therapies to keep clients in their homes.
13	Optional Service	Hospice	Assume 10% reduction through utilization controls	Hospice costs have risen substantially in last 5 years.	$10,015.3	Continuing work with provider association to analyze budget and potential savings.
14	Optional Service	Adult dental	Eliminate	Adult dental is an optional service for restorative treatments; it does not cover preventive measures. Many health plans, including Medicare, do not include dental services.	$51,428.2	Impacts approximately 172,000 clients.
15	Optional Service	Dental grants	Eliminate new grants for FY13	State-only grants could be replaced by capital grants for dental clinic equipment (e.g. dental chairs, etc.)	$1,000.0	
16	Optional Service	Adult podiatry	Limit service to diabetics	Retain adult podiatry for nail maintenance and other foot conditions for persons with diabetes. Eliminate service for other adults.	$5,200.0	
17	Optional Service	Durable medical equipment	Assume a 10% reduction through utilization controls	DME costs have risen substantially in the last 5 years.	$15,008.8	Continuing work with provider association to analyze budget and potential savings.
18	Optional Service	Home health	Assume a 10% reduction through utilization controls	Home health costs have risen substantially in the last 5 years.	$11,000.0	Continuing work with provider association to analyze budget and potential savings.
19	Utilization Controls	Hospitals: Detox services in acute hospitals	No readmission within 30 days; authorize 12.5+ hour observation only	Most state Medicaid programs do not offer inpatient detox services. There were 22,000 inpatient admissions in CY2010, where substance abuse was key reason for admission, at average cost of $2,000. Unlikely that these clients are engaged in a serious regimen of rehabilitation.	$25,492.4	Estimate assumes 70% of detox services without complications would be done in observation setting.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
20	Utilization Controls	Hospitals: baby deliveries	No pay for scheduled c-sections prior to 39 weeks - unless medically necessary; pay only normal vaginal delivery rate.	Advocates for improving birth outcomes have national campaign to reduce incidence of scheduled (elective) deliveries <39 weeks. Best outcomes are achieved when babies are born at full-term via normal vaginal delivery.	$2,854.0	
21	Utilization Controls	Bariatric (weight loss) surgery	Impose utilization controls	Adopt Medicare standard with patient responsibility (six-month medically supervised weight loss program under primary care physician) and surgery at a Center of Excellence.	$3,000.0	Impacts approximately 1,320 clients.
22	Utilization Controls	Eligibility for nursing facilities - change DON from 29 to 37 for new admissions only	Change DON from 29 to 37	Determination of Need (DON) is tool used for seniors and people with physical disabilities applying for nursing facilities and supportive living facilities (SLF - see #24 below). Policy will target Medicaid long-term care dollars to clients with highest needs. New DON score would apply to applicants for nursing facilities and SLFs in HFS budget; also for applicants for all home and community-based Medicaid programs administered by sister agencies, Depts. of Human Services and Aging.	$4,400.0	Assumes a 6 month FTE impact. Savings based upon approximately 1,000 new admissions below a 37 DON score.
23	Utilization Controls	Eligibility for supportive living facilities (SLF) - change DON from 29 to 37 for new admissions only	Change DON from 29 to 37	same as above	$3,300.0	Savings based upon approximately 1,300 projected new admissions below a 37 DON score.
24	Utilization Controls	Ambulance services	Repeal law requiring ambulance transportation between 24-hour medically monitored institutions (i.e. hospitals/nursing homes). Continue process of clarifying standards and prior approvals for ambulance transports.	Recent law and IDPH rule require full ambulance for transport from one facility with 24-hour medical monitoring to another such facility; adds excessive and unnecessary cost to transportation budget.	$1,500.0	Impacts approximately 30,000 clients.
25	Utilization Controls	Wheelchair repairs	Require prior approval on wheelchair repairs	Current administrative rule states repairs do not require prior approval as long as the repair is less than 75% of the purchase price.	$800.0	

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
26	Utilization Controls	Pharmaceuticals - prescriptions in Long Term Care settings	Require pharmacies to dispense brand name drugs in days' supply of less than 30 days for recipients in long term care settings	Changes policy based on Medicare rule. Pharmacies typically dispense maintenance medications to residents of long-term-care settings in 30-day supplies, but this leads to waste when a resident dies, changes medications, is hospitalized, or otherwise leaves the facility.	$150.0	Medicare Part D implemented a policy effective 1/1/2012 requiring pharmacies to dispense drugs in 7-day rather than 30-day supplies for LTC residents, initially limited to brand name drugs as a transitional approach. HFS will implement similar policy. Impacts approximately 1,000 clients.
27	Utilization Controls	Hospital readmissions	Establish performance-based payment system related to "potentially preventable events"	HFS is in process of establishing benchmarks for hospitals to measure and align payments to reduce hospital admissions/readmissions, inpatient complications and unnecessary ER visits. Modeled on Medicare policy to take effect 10/1/12.	$40,000.0	Suggested by and cost estimate furnished by IHA
28	Utilization Controls	Pharmaceuticals - limits on adult prescriptions	Limit adult prescriptions to five per month - but can be increased based on prior authorization	Prescription drugs are an optional service under Medicaid, but are needed to help clients with acute and chronic medical conditions. Currently, there is no limit on the number of prescriptions a client can fill. Our plan would limit prescriptions to 5 without doctor certification of need, reducing unnecessary medication and negative drug interactions.	$136,000.0	Impacts approximately 200,000 clients.
29	Utilization Controls	Pharmaceuticals - limits on children's prescriptions	Limit children's prescriptions to five per month - but can be increased based on prior authorization	Same as above. It is believed that children with more than 5 prescriptions will benefit from a physician's review of possible overuse and negative consequences of interactions among	$10,000.0	Impacts approximately 47,000 clients.
30	Utilization Controls	Pharmaceuticals - medication therapy management	Pilot project to test effectiveness	Pharmacists suggest cost savings when the pharmacist is incentivized to provide consumer education and care coordination services.	$500.0	Proposed by IRMA.
31	Utilization Controls	Pharmaceuticals - cost avoidance	Cost avoidance at point of sale. Reject claims where a patient has a third party payer that has not been billed primary	Change from pay-and-chase model: reject pharmacy claims at the point-of-sale for patients with other coverage when the pharmacy has not first billed the liable third party.	$40,000.0	Impacts approximately 155,000 clients with other insurance than Medicaid.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
32	Utilization Controls	Pharmaceuticals - hemophilia protocols/clotting factor reimbursement	New protocols for treatment of hemophilia patients; new reimbursement methodology for clotting factor products	Policy will target this expensive medical condition to achieve better disease management and reduced spending on blood factor. Policy will reduce practice where hemophilia patients will fill more blood factor than is necessary.	$11,995.3	HFS spends over $40M on blood factor each year for 250 Medicaid clients with hemophilia. In the state-only hemophilia program, HFS covers another 250 clients, and spends about $19M (costs less because many have primary insurance and use the program only after they have reached their cap with their primary insurance).
33	Utilization Controls	Pharmaceuticals - combination HIV medications	Implement prior approval requirement for combination HIV medications. Require patients to fill each individual drug separately.	Requiring prior approval for combination products will shift utilization to less expensive individual products for patients without compliance concerns, and will have no adverse impact. In patients where adherence is a concern, HFS would approve the combination products.	$3,000.0	Impacts approximately 4,500 clients.
34	Utilization Controls	Pharmaceuticals - cancer/biologicals	Implement prior approval, utilization limits and pricing strategies on certain physician administered drugs	To incent choice of lower cost drugs and to avoid improper use of high cost drugs administered by physicians	$5,000.0	Impacts approximately 10,000 clients.
35	Utilization Controls	Pharmaceuticals - transplants medications	Require prior approval for brand immunosuppressive products that have generic equivalents. Work with hospitals to initiate immunosuppressive drug therapy for transplant patients with generic drugs, rather than expensive, brand name drugs.	Cost savings for ongoing maintenance medication will be achieved if the patient is put on a regimen of less expensive drugs when first prescribed in the hospital.	$2,700.0	Proposed by IRMA.
36	Utilization Controls	Intermediate Care Nursing Facilities - Moratorium	Moratorium on new admissions to intermediate care nursing facilities	Care for "intermediate care" residents in nursing facilities -- who in Illinois tend to be people with mental illness -- is an optional service. Rather than eliminating the service and discharging current residents, this policy would put a moratorium on new admissions. Focuses resources of Medicaid program on higher-need clients who need residential placements.	$114,100.0	Impacts about 14,900 new admissions per year.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
37	Utilization Controls	Institutions for Mental Disease - Moratorium	Moratorium on new admissions to institutions for Mental Disease (IMD) - state-only program	State-only program for people with mental illness. Rather than eliminating this optional service and discharging current residents, this policy would put a moratorium on new admissions. Focuses resources of Medicaid program on higher-need clients who need residential placements.	$36,851.2	Impacts approximately 1,800 new admissions per year.
38	Utilization Controls	Veterans' benefit enhancement	Move services to federal VA for qualifying veteran clients	Offset Medicaid costs by shifting eligible veterans to better services provided by federal VA facilities.	$2,000.0	Proposed by Illinois Department of Veterans Affairs; there will be administrative impact for that department's veterans services officers.
39	Utilization Controls	Incontinence supplies	Quantity limit of 200 per month (from 300)	Cost savings are achieved through prevention of overuse, and accumulation of unused supplies.	$5,000.0	Cost savings based on quantity limit of only 200 combination of diapers or briefs (includes kids).
40	Cost Sharing	Hospital co-pay non-emergent use of emergency room services	Impose a $10 co-pay for non-emergency use of emergency room services.	Creates an incentive for clients to avoid inappropriate use of emergency room services.	$9,000.0	Proposed by IHA and 2011 Medicaid reform law. Cost savings estimate provided by IHA.
41	Cost Sharing	Pharmaceuticals - co-pays	Co-pays for generics - consider waiver to federal government for all incomes	Currently, for adults, brand name drugs require a $3 co-payment and generic drugs have no co-payment. Requiring a co-payment for generic drugs for adults would generate significant savings, and would also help ensure patients fill only those prescriptions that they need.	$14,300.0	Impacts approximately 900,000 clients. Savings value assumes a $1 co-pay.
42	Cost Sharing	Children receiving home services in Medically Fragile/Technology Dependent (MFTD) Medicaid Waiver	Changes in waiver to reflect cost-sharing based on parental income and new flexible rules for families, reducing utilization	Cost savings are achieved through cost-sharing, as allowed by federal law, and through incentives for consumer-directed care that offers flexibility.	$15,000.0	Waiver expires 8/1/12; policy decision (in statute) must be made during spring session.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
43	Cost Sharing	Federally Qualified Health Centers	Require co-pays	Incentivize proper service utilization through requiring clients to cover part of the expense.	$2,919.3	Implement for clients currently subject to co-pays, but for services not already subject to co-pays. Reflects value of a $3 co-pay increase.
44	Rate Adjustment	Long term acute hospital (LTAC) rates for ventilator-dependent patients	Rewrite recent law that substantially increased rates, with annual rate increases	Adjust the rates for clients requiring ventilator services in 7 long term acute hospitals to rates that are commensurate for similar patients receiving similar services in nursing facilities (highest rate). Recent law in IL increased base rates substantially for LTACs, which, if they now comply with several requirements, can receive adjustments up to 190% of their base rates or payments of $1,745 per day.	$39,600.0	Assumes 50% of days converted to the LTC rate.
45	Rate Adjustment	Federally Qualified Health Centers	Eliminate need for HMO wrap-around payment	Require managed care organizations (MCOs) to pay FQHCs full cost, so that state has no obligation to pay wrap-around payments. MCO rates are built upon full FQHC costs.	$13,200.0	
46	Rate Adjustment	Nursing Facility - capital rate	Lower the return on investment percentage in the capital portion of the nursing facility rate	Policy assumes a more reasonable 4% return on investment than currently.	$71,125.5	
47	Rate Adjustment	Nursing Facility - nursing rate	Eliminate $10 add-on for clients with DD	Based on a 22-year old policy from 1990, there is no remaining service requirement for this add-on, which was originally created for specialized services programs.	$472.0	Impacts approximately 130 clients.

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
48	Rate Adjustment	Excellence in Academic Medicine	Eliminate	State can no longer afford these extra payments to 11 teaching hospitals.	$13,800.0	$13.8 million gross GRF impact. $27.6 million gross all funds impact.
49	Rate Adjustment	Nursing Home/SLF bed holds	Eliminate bed hold for adults age 21 and over in LTC, including SLFs	There is no justification for additional reimbursements for nursing facilities and supportive living facilities for holding beds for Medicaid clients during periods of temporary absence (i.e. hospital admission).	$8,305.0	
50	Rate Adjustment	Supportive Living Facility rates	Delink rate increase from new nursing home tax funded nursing home rate increase	Without a rule change, SLFs will receive an automatic rate increase from the recent assessment-funded nursing home rate adjustment; SLF rates are set at 60% of nursing home rates (same for hospice).	$20,800.0	
51	Rate Adjustment	Power wheelchair rates	Reimburse for power wheelchairs at actual purchase price rather than current practice of Medicare rate minus 6%.	Allow for equitable payments to providers while saving HFS money.	$1,900.0	
52	Care Coordination	Initiatives being launched in FY13 include: Integrated Care Program Phase II, Dual Eligibles Capitation Demonstration, Innovations Program - adults, Innovations Program - children	Focus on most expensive clients with complex health/behavioral health needs	Care coordination is most important and cost-effective plan for improving Medicaid service delivery, and is required by 2011 Medicaid reform law (50% of clients by 1/1/15). Modest savings in FY13 are assumed due to mid-year implementation, start-up delays and gradual enrollment of clients.	$16,075.0	In addition to $16 million projected cost savings, FY13 budget already assumes $23 million in savings related to Phase I of Integrated Care -- or $39 million in total.
53	Other	Recipient Eligibility Verification Vendors (revenue item)	Increase the number of vendors with connections to HFS systems and increase fees for transactions processed through those connections.	In order to require electronic verification of eligibility by providers at the point of service, HFS will allow more entities to have direct system connections to HFS data, will increase the number of transactions for which it charges a fee and will increase the fees charged.	$1,000.0	

FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
54	Other	Reform private insurance market	Increase the number of children with special healthcare needs who have their needs met with private insurance -- who now use both private insurance and Medicaid.	Goal is to share responsibility with the health insurance industry for covering children with special needs. Under federal law, these children can no longer be excluded on the basis of preexisting conditions, but the coverage needs to be expanded to allow families to keep children in the home with the proper supports.	$250,000.0	More realistic possible savings related to Children's Memorial Hospital proposal.
55	Other	Hospital outpatient drugs - rebates (revenue item)	Reimburse hospital outpatient drugs separately in order to collect manufacturer rebates.	Hospitals are now reimbursed for outpatient drugs through established outpatient hospital rates. If payments for outpatient drugs are segregated and made separately, it would make that spending eligible for manufacturer rebates. Inpatient drugs are not eligible for rebates.	$20,000.0	Proposed and cost savings estimate developed by IHA.
56	Other	Third party liability	Contract with vendor to enhance HFS' current collections efforts.	Implement 2011 Medicaid reform. Invitation for Bids was published on March 19, 2012. Bids are due on April 21, 2012.	$10,000.0	
57	Other	Recovery audit contractor (RAC)/payment recapture audits	Implement RAC audits as a supplement to Inspector General's reviews.	Under federal Affordable Care Act rules and 2011 Medicaid reform law, HFS will contract with Recovery Audit Contractors (RAC) to audit payments to medical providers. Focus will be on provider types not currently under close scrutiny.	$21,875.0	Estimated gross savings of $25 million is offset by an assumed contingency fee of 12.5 percent (maximum allowed by federal rules - could be less), or $3.125 million.
58	Other	Improving birth outcomes	Develop a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with babies being born with low and very low birth weight and fetal death	Illinois will use successful Michigan model of intensive care coordination for high-risk pregnant women and mothers.	$25,000.0	
			Grand Total		**$1,382,090.2**	
	Note:					
	Savings figures reflect 12 month values and assume a July 1, 2012 date of service start date unless otherwise noted. The figures will need to be modified for any change to that date and for provider billing lags.				

Medicaid Stabilization – Fact Sheet

- The Medicaid system is on the brink of collapse and the $2.7 billion hole in Medicaid must be addressed this spring.
- The Governor has a plan that addresses the entire $2.7 billion problem with three components: $2 billion (75 percent) reductions, a $1 per-pack cigarette tax and taking advantage of federal matching dollars.
- Without solving the Medicaid crisis this spring, the program will devastate next year's fiscal year's budget (the budget that will be passed in May), limiting our ability to fund critical state priorities, including education, public safety and the capital construction program.

Background

Illinois' Medicaid program is on the brink of collapse. The program, which provides health care to 2.7 million Illinois residents in need, will end this current fiscal year (though June 30) with **$1.9 billion in unpaid bills**. Unless we take action to fundamentally restructure Medicaid this session, the Civic Federation estimates **$21 billion** in unpaid Medicaid bills by 2017.

Medicaid and pensions now account for **39 percent** of state general revenue spending, putting a tremendous squeeze on the rest of our budget and impacting Illinois' ability to provide other essential services, such as education and public safety.

We must save our Medicaid program in order to continue providing services that millions of Illinois residents depend upon. The status quo is not an option**. Every day without action to stabilize Medicaid only makes the problem worse** and will lead to additional service reductions.

How did we get here?

- **Program costs** have risen 6 percent per year since 2008, due to significant enrollment growth from the recession and Illinois' reliance on a fee-for-service system;
- The **expiration of the federal stimulus**; and
- Last year's **deferral of $1.9 billion** in Medicaid bills to future years.

Stabilizing the Medicaid System

2011's Medicaid reforms, championed by Governor Quinn, are helping to tighten eligibility and move Illinois to a managed, coordinated system of care. However, we must still **reduce Medicaid expenditures in the program by $2.7 billion in the coming year** to prevent the system from collapsing.

In his February budget address, the Governor called for $2.7 billion in savings to Medicaid liability this session. The Governor convened a **working group** – comprised of members from each of the four legislative caucuses – to explore all options and develop a framework to save our Medicaid system.

The working group met with and incorporated suggestions from many provider groups, including: hospitals, podiatrists, durable and disposable medical equipment companies, long-term care providers, dentists, pharmacists, and hospice providers.

The Governor has proposed a plan to stabilize Illinois' Medicaid system by reducing Medicaid liability by $2.7 billion – a plan comprised of three-quarters cuts, reductions and efficiencies.

- Cuts, reductions and efficiencies to 58 separate items totaling $1.35 billion (50 percent)
- Rate reductions to providers totaling $675 million (25 percent)
- Additional revenue through a $1 per pack increase in the cigarette tax totaling $337.5 million (12.5 percent)
- 100 percent federal match funding from the increased cigarette tax totaling $337.5 million (12.5 percent)

The cuts, reductions and efficiencies across 58 separate items in the Governor's proposal include:

- Program integrity to prevent client and provider fraud
- Elimination or reduced coverage of certain optional populations and services
- Controls on use of Medicaid services to prevent over-use or waste
- Adjustments to rates that are outdated or do not reflect budget realities
- Expanded cost-sharing by clients
- Redesigned healthcare delivery system through Coordinated Care
- Complete implementation of all reforms in 2011 Medicaid reform law

Limiting Medicaid liability through revenues raised by increasing the cigarette tax is a crucial component of the Governor's plan because it is good fiscal and public policy:

- According to the American Cancer Society, tobacco use cost Illinois $1.5 billion last year in Medicaid spending.
- The revenue raised by the **federal match accounts for a full one-eighth** ($337.5 million per year) of the savings we need to find in the Medicaid program.
- Beyond the direct revenue, raising the cost of cigarettes by a dollar will improve the health of the people of Illinois, **reducing tobacco-related Medicaid and health care costs** over the long-term.
- Again according to the American Cancer Society, raising the cigarette tax will prevent **more than 70,000 children** from becoming addicted adult smokers, decrease youth smoking by 11 percent and save more than 38,000 Illinois residents from premature, smoking-caused death.
- In its FY2013 Illinois Budget Roadmap, the **Civic Federation supported increasing the state tax on cigarettes** from the current rate of 98 cents per pack to $1.98 per pack in FY2013 to reduce the State's budget deficit and to fund public health expenses in future years.

Result of Medicaid Stabilization

The Governor's proposal will ensure Illinois is able to continue its Medicaid program.

It is respect for the doctors, clinics, hospitals, nursing homes, and pharmacists who provide care under the Illinois Medicaid program, often under very challenging circumstances, that must motivate us to work together to save the entire program from collapse. Our goal is to create a high quality Medicaid program that is sustainable for this year and years to come.

We must implement a program to stabilize Illinois' Medicaid system as soon as possible. The longer we delay without implementation, the larger the hole in the Medicaid program becomes and the closer the program moves to collapse.